Hospital Management

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The New York Hospital

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news and technical journal of administration

July • 1952

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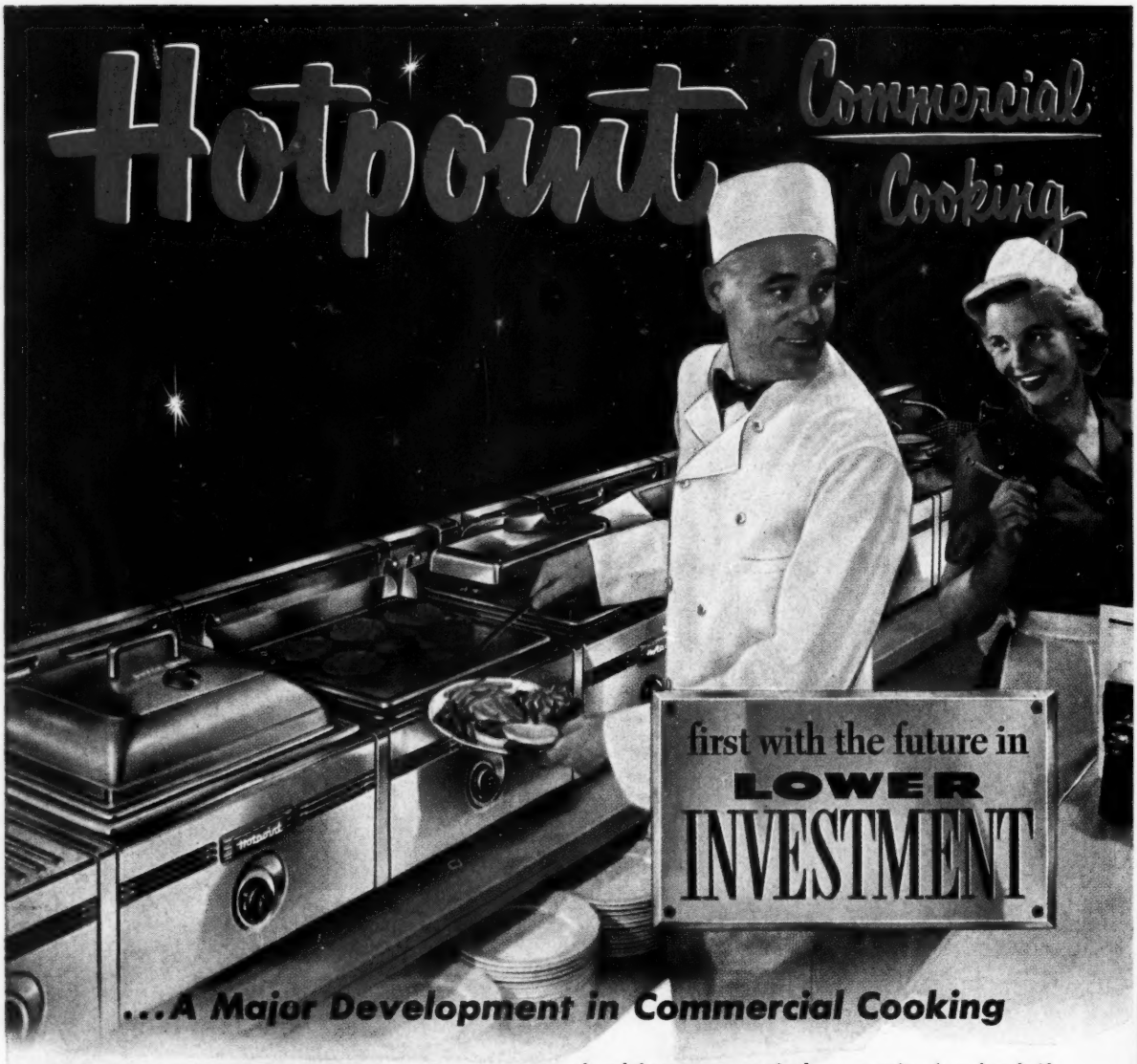

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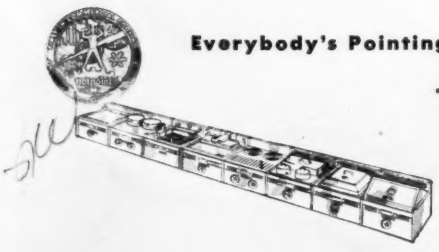

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Publisher's Announcement

Ever since I established Hospital Management in 1916, I have had great satisfaction in serving the field of hospital administration, and in recording the remarkable progress of hospital service. The growth of hospitals and the improvement of methods for the care of the sick have made this a highly interesting and stimulating field in which to work as a publisher. I have enjoyed it immensely.

Hospital Management is keeping pace with the rapid expansion of the hospital field. My own publishing activities, however, have become so diversified in recent years that I feel unable to give to Hospital Management the increased time and attention which its importance and the development of the field will require from now on. I have therefore considered resigning my position as publisher and president of Hospital Management, Inc., provided I could transfer my interests and responsibilities to a company well qualified by experience, standing and ability to carry on the magazine in the best interests of hospitals and their administrative staffs.

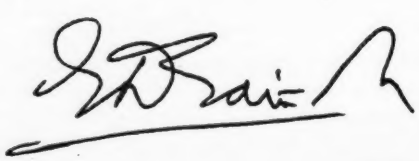
I am now happy to announce that I have made such an arrangement. My successor as publisher, immediately following the appearance of this issue, is Paul E. Clissold, president of the Clissold Publishing Co., of Chicago. This is one of the oldest and best known business publishing houses in the country. It has been in business for more than 65 years, and Mr. Clissold is the third generation of his family represented in the company.

Besides heading the Clissold Publishing Co., Mr. Clissold is also chairman of the board of the Associated Business Publications, leading national association of business publishers. Hospital Management, incidentally, has been a member of this association for many years, and is the only hospital journal enjoying this distinction.

The members of the editorial and business staffs of Hospital Management will continue their services to readers and advertisers as heretofore. Kenneth C. Crain, vice-president and Eastern editor, who has been active in the conduct of the magazine since 1919; Frank Hicks, executive editor; F. James Doyle, associate editor, and the members of the business staff will maintain their accustomed contacts with the hospital world, through which they will continue to render the service which has made Hospital Management such a popular and practical journal of administration.

In leaving Hospital Management, I desire to express my great appreciation to them for their loyal and efficient efforts in behalf of the magazine and of the hospital field; to our readers, who have given Hospital Management the largest voluntary paid hospital circulation ever established by a hospital magazine; and to our advertisers, whose use of our pages has made possible the service of editorial information which we have been able to provide during the past thirty-six years.

I shall be available to the new publisher of Hospital Management at all times for consultation, and I hope to remain in close touch with the many important developments which make the growing hospital field of such interest to all concerned with public health service. In the meantime, I extend my best wishes to you and to Mr. Clissold, the new publisher of Hospital Management.



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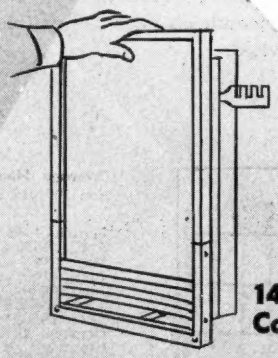

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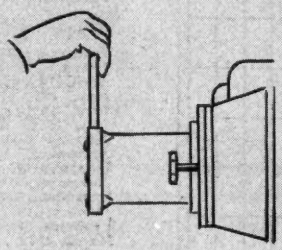

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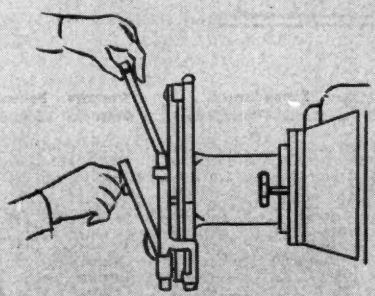

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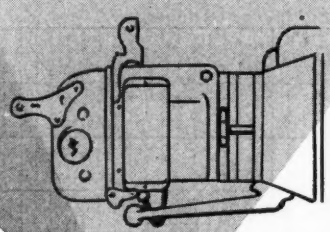

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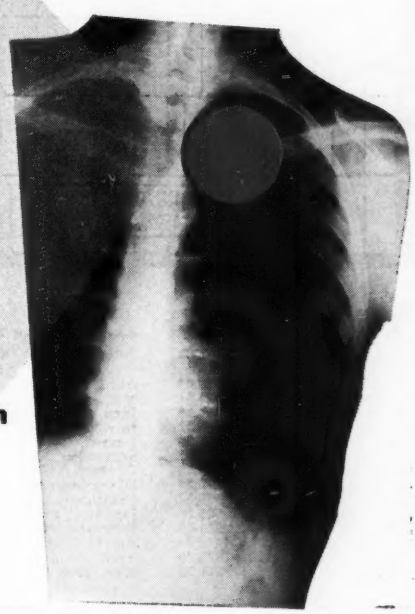


You can put your confidence in —

GENERAL ELECTRIC

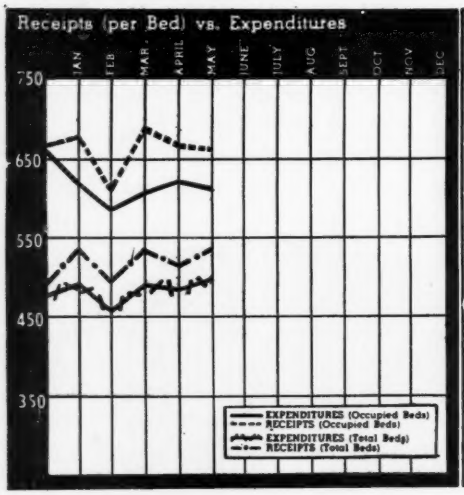
new how's business department with the american association of hospital accountants

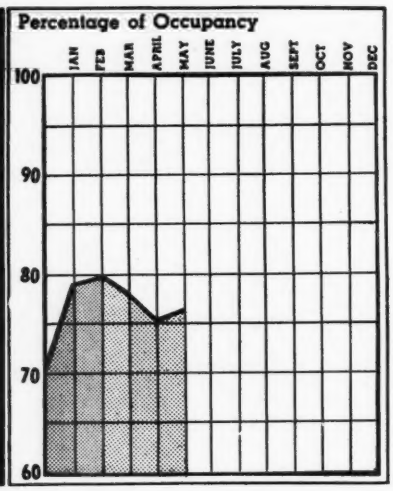
by F. James Doyle

■ INFORMATION GATHERED FROM HOSPITALS which are respondents of the monthly How's Business survey showed again a striking similarity of May's activity with that of the preceding March, especially as regards the national averages. The only unusual statistic . . somewhat reversing ordinary trends for the month . . is the rise in the percentage of accupancy; but that, too, is comparable with those of 1951 and 1950, percentage-wise.

Readers of this department will find the article promised last month on page 116 of this issue. Comments are invited.

National Averages





Average Monthly Occupancy (on 100 per cent basis)

March, 1950	79.20
April, 1950	77.67
May, 1950	76.54
June, 1950	76.26
July, 1950	73.38
August, 1950	74.90
September, 1950	73.62
October, 1950	77.10
November, 1950	76.63
December, 1950	71.57
February, 1951	81.82
March, 1951	82.05
April, 1951	78.60
May, 1951	76.98
June, 1951	79.50
July, 1951	75.70
August, 1951	75.72
September, 1951	76.84
October, 1951	77.26
November, 1951	75.70
December, 1951	71.13
January, 1952	78.81
February, 1952	80.87
March, 1952	78.26
April, 1952	75.58
May, 1952	76.97

Av. Operating Expenditures Per Occupied Bed Per Month

April, 1951	580.44
May, 1951	623.84
June, 1951	568.14
July, 1951	566.22
August, 1951	623.94
September, 1951	584.22
October, 1951	593.68
November, 1951	597.14
December, 1951	668.52
January, 1952	623.00
February, 1952	584.28
March, 1952	612.34
April, 1952	623.20
May, 1952	611.28

Average Patient Charges Per Occupied Bed Per Month

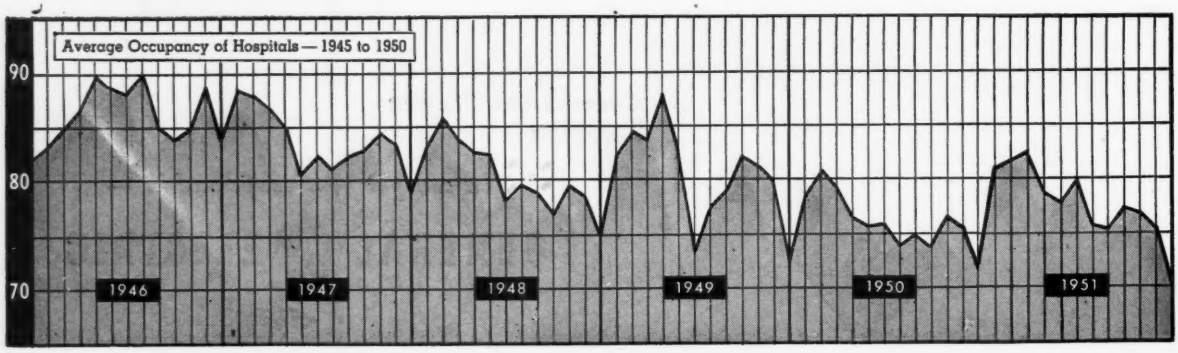
April, 1951	606.60
May, 1951	664.22
June, 1951	589.15
July, 1951	588.05
August, 1951	641.61
September, 1951	610.90
October, 1951	644.73
November, 1951	625.06
December, 1951	662.84
January, 1952	676.14
February, 1952	613.31
March, 1952	671.51
April, 1952	668.79
May, 1952	664.25

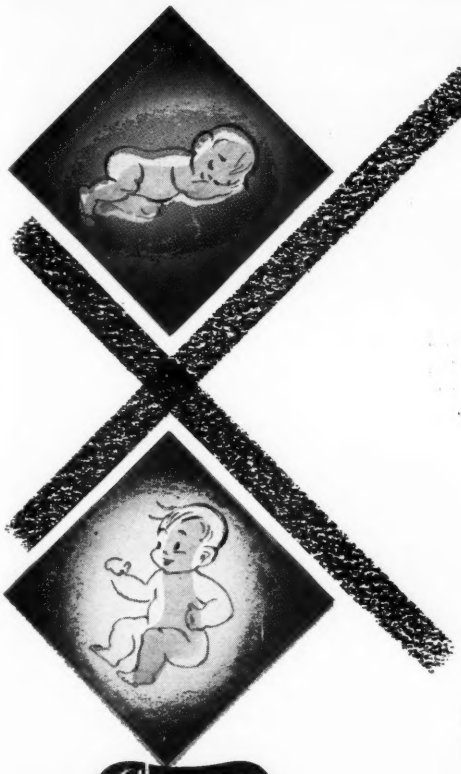
Av. Operating Expenditures Per Bed Per Month (Total Beds)

April, 1951	460.21
May, 1951	488.40
June, 1951	452.67
July, 1951	433.33
August, 1951	474.23
September, 1951	451.99
October, 1951	462.48
November, 1951	464.99
December, 1951	484.14
January, 1952	494.92
February, 1952	463.92
March, 1952	485.82
April, 1952	479.44
May, 1952	490.18

Average Patient Charges Per Bed Per Month (Total Beds)

April, 1951	488.87
May, 1951	520.01
June, 1951	469.41
July, 1951	450.03
August, 1951	487.66
September, 1951	472.62
October, 1951	502.26
November, 1951	486.73
December, 1951	479.44
January, 1952	537.13
February, 1952	497.53
March, 1952	532.76
April, 1952	514.51
May, 1952	532.64





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May 1952 regional how's business report

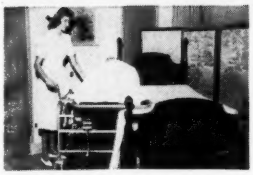
REGION →	NEW ENGLAND Connecticut, Maine, Mass., N. H., R. I., Vermont			MIDDLE ATLANTIC New Jersey, New York Pennsylvania			SOUTH ATLANTIC Del., Fla., Ga., Md., N. C., S. C., Va., W. Va., D. C.			SOUTH CENTRAL Ala., Ky., Miss., Tenn., Ark., La., Okla., Texas		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AV. NO. OF ADULT PATIENT DAYS	1,082	3,179	11,832	1,785	4,314	8,989	1,493	4,856	8,781	1,424	3,618	8,758
% of OCCUPANCY	57.53	74.86	85.86	80.66	80.99	88.62	59.95	83.77	74.10	73.78	72.83	81.50
EXPENSES BY DEPTS.		Per Patient		Day				Per Patient		Day		
Administration	$1.87	$2.04	$2.68	$1.36	$2.17	$1.83	$1.15	$2.04	$2.43	$1.40	$1.68	$2.16
Dietary	3.16	2.84	3.60	2.81	3.03	3.54	2.50	4.01	3.58	2.07	2.62	2.95
Housekeeping	.79	1.28	1.14	.79	.89	1.02	1.14	1.11	1.12	.65	1.11	1.00
Laundry	.58	.52	.54	.50	.49	.46	.42	.45	.66	.48	.45	.40
Plant Operation	1.64	1.48	1.55	1.17	1.39	1.26	.78	1.93	1.95	.98	1.03	1.13
Medical & Surgical	.83	1.07	1.14	.45	1.12	.77	.72	1.93	2.01	.76	1.21	1.37
O. R. & Del. Rms.	1.04	1.19	1.23	1.04	1.00	.90	.38	1.13	1.59	.78	1.04	1.49
Pharmacy	.99	.94	.71	.72	.70	.88	.36	1.12	1.25	1.22	.91	1.24
Nursing	5.45	5.69	4.98	3.67	4.54	4.44	3.34	4.15	6.15	3.34	4.75	4.35
Anesthesia	.38	.53	.51	.48	.50	.44	.33	.25	.74	.52	.89	.81
Laboratory	.66	.89	1.14	.60	1.16	.81	.15	.76	1.11	.45	.88	1.47
X-ray	.89	1.36	.86	.95	1.25	.69	.22	.50	1.12	.51	.57	.93
Other special services	.12	1.31	.88	.15	.46	.80	.35	.53	.79	.24	1.37	.96
TOTAL EXPENSES	18,161	67,203	246,598	26,578	80,564	158,750	16,931	94,167	209,446	18,531	64,117	170,946
TOTAL CHARGES TO PATIENTS	19,691	68,677	268,979	27,540	91,255	184,318	20,894	101,149	197,989	19,866	74,051	195,064
OPERATING INCOME PER PATIENT DAY	18.40	21.60	22.73	15.43	21.15	20.50	11.34	19.39	23.85	13.95	20.47	22.27
OPERATING EXPENSES PER PATIENT DAY	16.78	21.14	20.84	14.89	18.67	17.66	13.99	20.83	22.55	13.01	17.72	19.52

REGION →	EAST NORTH CENTRAL Illinois, Indiana, Michigan Ohio, Wisconsin			WEST NORTH CENTRAL Kans., Iowa, Minn., Neb., N. D., S. D., Mo.			MOUNTAIN STATES Ariz., Colo., Idaho, Mont., Nev., N. M., Utah, Wyo.			PACIFIC COAST California, Oregon, Washington		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AV. NO. OF ADULT PATIENT DAYS	1,573	3,463	8,489	1,474	4,356	10,929	1,382	3,847	5,779	1,628	4,051	6,080
% of OCCUPANCY	72.62	79.34	83.62	75.08	77.82	86.20	67.02	82.37	80.59	69.20	77.05	74.47
EXPENSES BY DEPTS.		Per Patient		Day				Per Patient		Day		
Administration	$1.68	$1.91	$2.23	$1.56	$1.96	$1.55	$1.48	$1.50	$2.29	$4.23	$3.76	$3.81
Dietary	2.52	2.86	3.66	2.08	3.25	3.09	2.29	3.00	3.47	4.15	2.82	4.43
Housekeeping	.71	.90	1.29	.80	.84	.91	.92	.87	.85	1.51	1.54	1.81
Laundry	.56	.51	.54	.46	.54	.32	.50	.49	.41	.85	.81	.64
Plant Operation	1.29	1.47	1.76	1.01	1.42	1.23	.82	.95	1.04	1.41	1.78	1.72
Medical & Surgical	.95	1.08	1.23	.81	1.01	1.11	1.14	.77	1.30	.91	.96	1.79
O. R. & Del. Rms.	1.01	1.04	.90	.90	1.39	1.12	1.32	.99	1.55	2.17	2.07	2.75
Pharmacy	.72	.88	1.06	2.49	1.01	.92	1.98	1.25	.90	1.15	1.06	1.51
Nursing	5.13	5.63	5.28	4.30	4.25	4.88	3.24	4.60	4.73	6.84	9.21	7.92
Anesthesia	.57	.28	.29	—	.39	.53	.39	.44	—	—	.46	.58
Laboratory	.68	1.11	.80	.55	1.15	1.26	.63	.97	.99	3.08	1.51	1.91
X-ray	.87	.96	1.15	.85	.77	.53	.73	.69	1.01	2.77	1.20	1.53
Other special services	.50	.55	.58	.36	.34	.36	.13	.37	.58	—	2.63	.56
TOTAL EXPENSES	26,212	63,806	176,438	21,205	79,094	191,988	21,518	63,463	107,566	47,326	116,498	185,470
TOTAL CHARGES TO PATIENTS	27,331	70,795	180,368	25,876	86,343	206,499	23,190	67,235	122,416	58,251	122,684	193,153
OPERATING INCOME PER PATIENT DAY	17.37	20.44	21.25	17.55	19.82	18.89	16.78	17.48	21.18	35.78	30.28	31.77
OPERATING EXPENSES PER PATIENT DAY	16.66	18.42	20.78	14.39	18.16	17.57	15.57	16.50	18.61	29.07	28.76	30.50

EASY LIFT

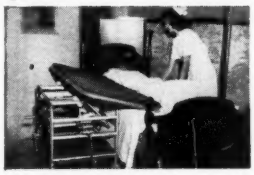
one nurse does the job of many

WHEEL STRETCHERS



A Turn of the Crank and the Stretcher Top Moves Over the Bed.

Continue turning the crank and the top tilts, locking into position.



A simple, safe movement and one nurse transfers even the heaviest patient.

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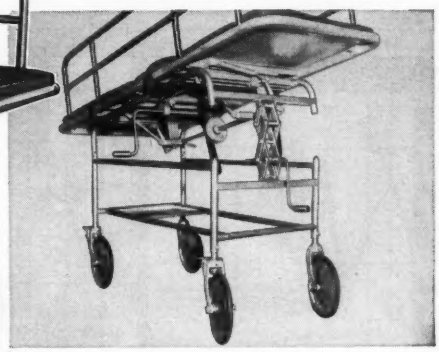
Today, more than ever before, America's busy hospitals need equipment that will save time and money. The Hausted "Easy Lift" stretcher has been developed to meet the problems brought about by the increasing number of patients and the extra work load which hospital staffs must carry. The "Easy Lift" will pay for itself in a short time through the labor saving it will effect. The Hausted stretcher does every job of patient transportation needed. With all or part of the optional equipment the "Easy Lift" is ideally suited for post-operative or recovery room use. All of the accessories are stored on the stretcher, ready for use when needed.



A feature of the Hausted Stretchers is the Trendelenburg Power Lift.

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WHEEL STRETCHERS

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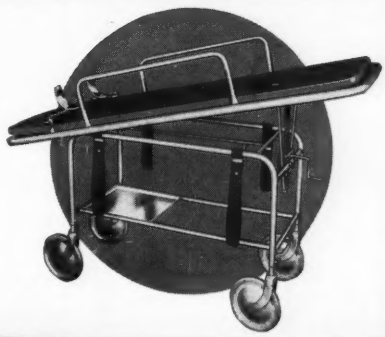
This is the feature that distinguishes Hausted Wheel Stretchers. The stretcher top fits 3¾ inches over the edge of the bed for easier, quicker, and safer patient transfers. The Hausted Standard Stretcher enables just two nurses to transfer even the heaviest patient without fear of disturbing or harming the patient and without strain to the attendants.

The "Standard" stretcher has many features that are not available in regular conventional stretchers, and yet, the cost is in the low price field. The "Standard" stretcher can be adjusted from 31 to 38 inches in height, which makes it possible for the Hausted "Standard" stretcher top to be the exact height of the beds in the hospital. The "Standard" stretcher's over-the-bed feature is outstanding among its many advantages. Special side rails and other optional equipment are available for post-operative or spinal anesthesia use.



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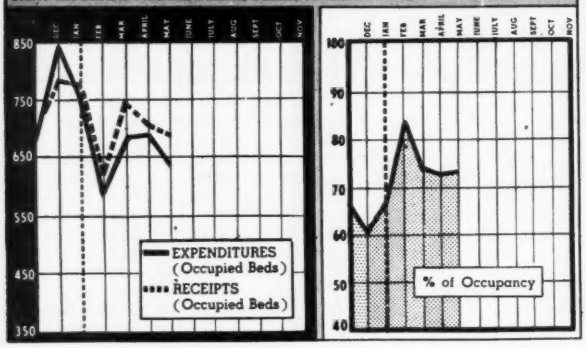
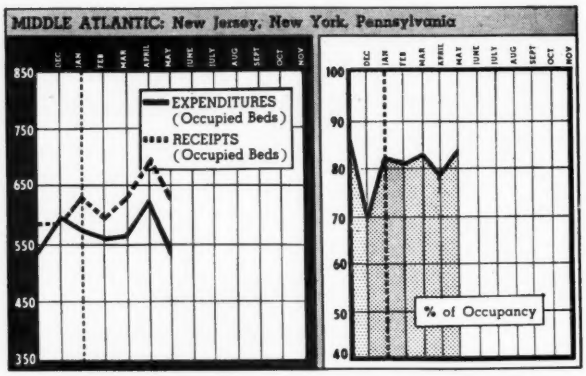
MEDINA, OHIO

May 1952 regional how's business report

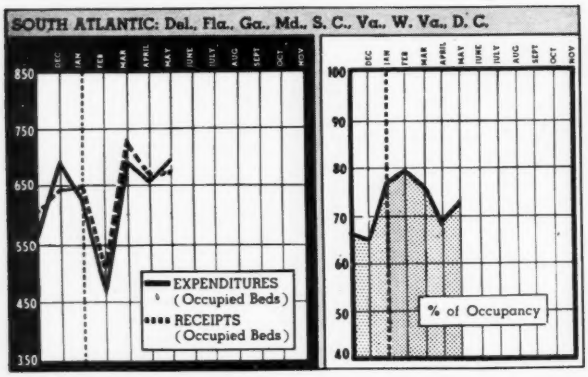
NEW ENGLAND: Conn., Maine, Mass., N. H., R. I., Vt.



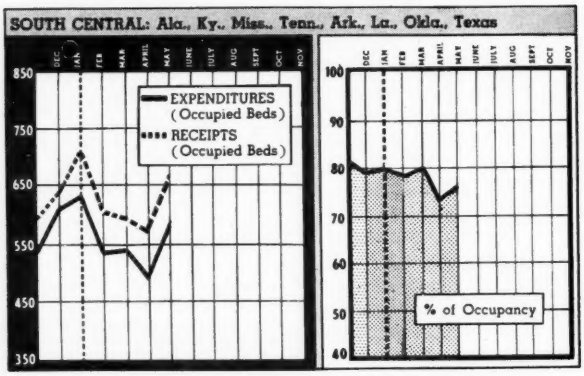
MIDDLE ATLANTIC: New Jersey, New York, Pennsylvania



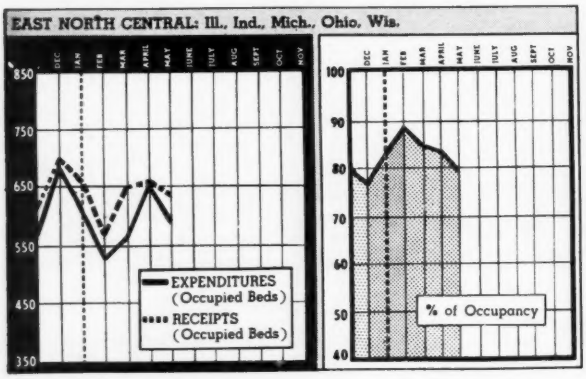
SOUTH ATLANTIC: Del., Fla., Ga., Md., S. C., Va., W. Va., D. C.



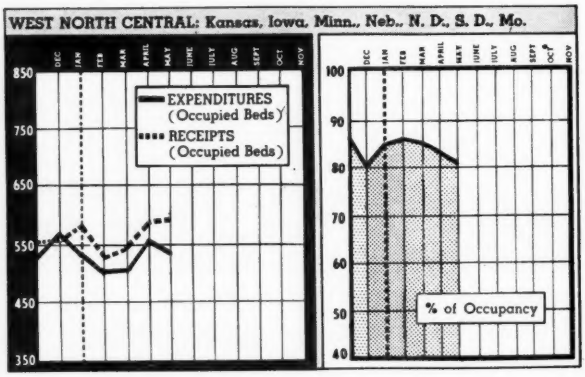
SOUTH CENTRAL: Ala., Ky., Miss., Tenn., Ark., La., Okla., Texas



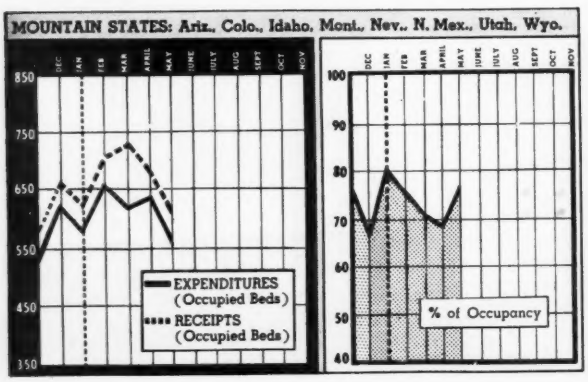
EAST NORTH CENTRAL: Ill., Ind., Mich., Ohio, Wis.



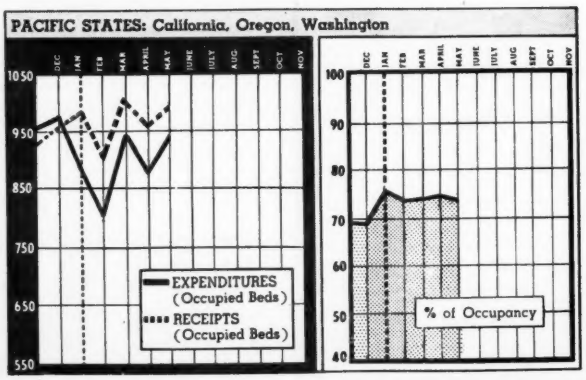
WEST NORTH CENTRAL: Kansas, Iowa, Minn., Neb., N. D., S. D., Mo.



MOUNTAIN STATES: Ariz., Colo., Idaho, Mont., Nev., N. Mex., Utah, Wyo.



PACIFIC STATES: California, Oregon, Washington



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'Free' medicine: hard to drop

Winston Churchill has a political bear by the tail in socialized medicine. He couldn't drop it now, even if he wanted.

The system is growing. Nine doctors in 10 take part; 48 out of every 50 Britons are customers of public health.

Socialized medicine turns out to be inefficient, hit or miss and dangerously costly. But the voters seem to love it.

LONDON

■ IT IS CLEAR NOW that socialized medicine is here to stay in Britain.

Winston Churchill is finding that the slightest bit of tinkering with the system costs votes. After Conservative Party setbacks in recent local elections, he shook up his Cabinet and brought in a new Minister of Health to handle the program that assures everybody of tax-paid medical care.

The fact is that the health program Churchill inherited from the Socialists has Britain's politicians over a barrel. Some of them say the cost is driving the country toward bankruptcy. And the system itself is shot through with inefficiency. But public health is so popular that any move to end it, or even to trim it, invites political disaster.

After nearly four years of experience, there is no serious agitation to return medical care to private practice. Roughly 90 per cent of all family doctors are enrolled in the health service. And 48 out of every 50 Britons are getting their doctoring through the public program.

A close look at public health shows some of the problems Mr. Churchill is up against if he ever tries seriously to "desocialize" in Britain.

Cost . . is a major concern. The Socialists, when they started the plan, guessed it would cost about $12 per person annually. Real per capita cost now is near $26 and it is still rising. The system is eating up more than a billion dollars of general tax revenue each year.

There are only the slightest signs of any letup in the public demand for medical care. Requests for spectacles and false teeth are slackening, now that the patient has to pay half the price. But the national appetite for tax-paid pills and medicines seems almost out of control. Hospitals are so jammed that 175,000 patients are on the waiting lists for nonemergency operations.

Family doctors . . are working under heavy pressure. Thousands of them are caring for the maximum of 4,000 regular patients allowed by the law. A recent poll shows what they are up against:

A typical family doctor is working

Reprinted from "U.S. News & World Report," an independent weekly news magazine published at Washington. Copyright 1952 United States News Publishing Corporation.

a 50-hour week now. He sees about 30 patients in his office and half that many on home calls. New patients requiring examinations may get 10 or 15 minutes with the doctor. Old patients get seven or eight. A patient can get a prescription in three or four minutes.

Many overworked doctors are adopting short cuts to handle the crowds. Some leave signed authorizations for eye examinations and spectacles in their waiting rooms where patients can pick them up. When an abscess needs lancing or a sprained ankle needs taping a family doctor in a hurry often sends the patient to the hospital after a brief diagnosis.

So far as it can be measured, however, the trend among doctors is to go along with socialized medicine. For two years before the program started, professional organizations agitated against it and even tried, unsuccessfully, to rally their members to a general boycott. There is no such talk now, nor is medicine losing out as a popular profession. Medical schools are packed.

The doctors are buoyed up at the moment by a substantial boost in pay. A typical country doctor with 2,000 patients has been getting about $4,800 a year, before deducting expenses of about 38 per cent. Under the new cost-of-living award he is to get about $5,600 a year. Specialists on full time with the health service are getting from $4,760 to $7,700 plus annual merit awards ranging from $1,400 to $7,000. They also are to get an increase.

Hospitals . . are the most acute problem in the health program, from a financial standpoint. The average cost per hospital bed occupied in London was $31.25 per week in 1947. Now the figure is almost double, and many institutions are hopelessly overcrowded. An estimated 10,000 tuberculous patients are eligible for hospital treatment, but they often have to wait from two to ten months before room can be found for them.

As to skyrocketing costs, one study blames the new hospital managers. "There seems to be almost a race to see how many improvements they can make in the shortest time, without regard to means."

Medicine . . for nonhospital patients is being passed out over the prescription counters in almost carload lots. Government money flowing into the drug industry to pay for public-health prescriptions has reached such proportions that some Socialists are saying the industry itself ought to be nationalized. About 5 million prescriptions a week are being filled . . double the rate before 1948 . . and they cost the Government around 50 cents each.

In the beginning, planners figured the British public would average about three prescriptions per person annually. They were way off. Take this example: In Hull, Eng-

continued on next page

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"...to talk of many things"

How safety program in Ohio hospitals cut accidents

■ A SAFETY PROGRAM in Ohio hospitals was set up as a result of cooperation between the plant and maintenance committee of the Ohio Hospital Association and the Safety and Hygiene Division of the Industrial Commission of Ohio. It was described May 27 at a sectional meeting of the Catholic Hospital Association at Cleveland, O.

The purpose of the program, it was said, was to fix normal responsibility upon appropriate personnel and to assure full discharge of duties; periodic inspection to detect hazards; investigation of all accidents to determine causes; prompt correction of hazards or work methods; competent and prompt treatment of injury; orderly recording and reporting of injuries; cooperation with the insurance carrier to facilitate fair and prompt adjudication of claims and education in safe practices.

Among the items to be inspected and corrected were listed certain specific hazards:

Fire-fighting appliances not ready for immediate use.

Hoods and flues over kitchen ranges not free from grease.

Failure to enforce rules against employes smoking except where smoking is permitted.

Paints and oils, all flammable materials or fluids not kept in their proper place.

Stairs, it was said, should be inspected for defective treads, coverings and hand rails; for insufficient illumination; and for mops, pails, trays and boxes.

Slippery floors, defective rugs or runners, spilled liquids left on the floor and mopping too large an area of the floor at once can cause serious accidents.

Attention to elevators and mechanical equipment was urged, not only inspection as to their safety but as to whether the operators are trained and authorized to operate the equipment.

William R. Williams, administrator, Good Samaritan Hospital, Sandusky, O., urged more precautions against accidents to hospitalized patients. He pointed out that a study of the causes of accidents to patients showed that about 40 per cent occurred around the bed.

R. W. Bachmeyer, director, Aultman Hospital, Canton, O., told how a safety program in the hospital materially reduced accidents. ■

Free medicine

continued from page 17

land, with a population of 300,000, the 114 doctors issued 600,000 prescriptions in the year before socialized medicine started. In the first year of the new program, prescriptions shot up to 1.7 million.

The Government now makes a nominal charge of 14 cents per prescription for all patients except those on public welfare, war pensioners and persons with war-connected disabilities. But the prescription trade has not slackened.

Physical aids . . and appliances are in less demand. At the beginning, Britons rushed for tax-paid spectacles at a pace exceeding 8.5 million pairs a year. Since mid-1951, they have had to pay half the price of their eyeglasses, with the result that demand has leveled off at about 5 million a year.

The same thing is true in the case of false teeth. Since the patient has been required to pay half, demand has eased off to below 1.5 million sets a year.

Dental care . . slowing down a bit after the initial stampede, still represents a big share of the health program. Ten out of eleven British dentists are treating public patients. Thousands of them devote full time to the work.

In the whole health program, charges of professional wrongdoing are comparatively rare, but it is the dentists who are most often in trouble. Some have been accused of overprescribing false teeth, for which they are paid the equivalent of $25 a set, of extorting fees and of other irregularities. About 100 dentists have been fined. A few have been barred from the service.

One result of the health program has been to reduce regular dental checkups in the schools. Many salaried dentists who formerly devoted full time to school examinations have quit for the better pay that goes with public practice. A school dentist usually earns less than $2,800 a year. The same man can double that amount caring for public patients.

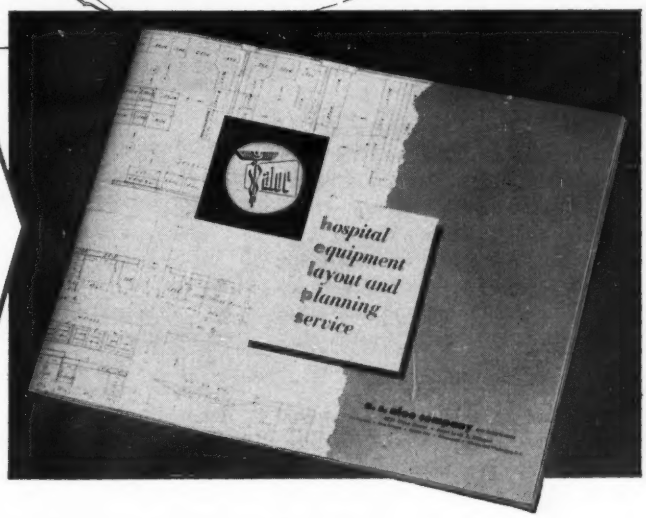
Public reaction . . to socialized medicine shows why politicians are

concluded on page 139

does your hospital planning program...

...have you running in circles?

Send for your free copy of this most helpful booklet today



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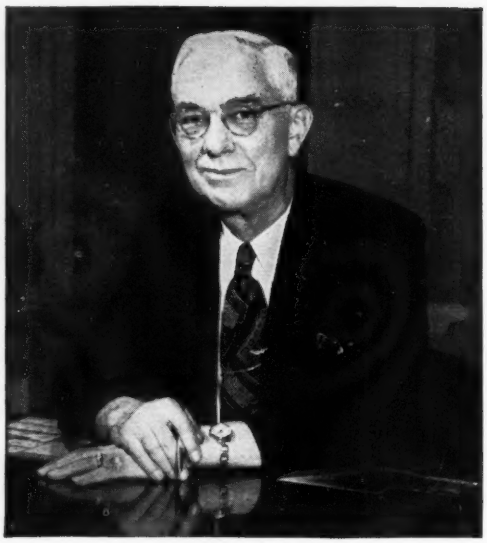
Dr. Ferguson's mailbag

Have you a medical audit?

If you have a medical audit in your hospital please send forms used and opinions to me at American College of Surgeons, 40 E. Erie St., Chicago 11, Ill.



Hospital standardization problems and answers

Dr. Paul S. Ferguson, who has succeeded Dr. Malcolm T. MacEachern as director of the hospital standardization program of the American College of Surgeons, and who will continue the work of answering hospital standardization questions on this page

■ PROBLEM: An administrator writes: Many of our surgical patients enter the hospital only a few hours before surgery, and operations are scheduled on short notice. Would it be permissible to write an admission note with the pre-operative diagnosis before surgery and the other information immediately after surgery?

■ ANSWER: The rules and regulations of the medical staff in most hospitals require that surgical patients be admitted by four o'clock the afternoon preceding surgery to give ample time for the preparation of medical records, making laboratory examinations, etc. That rule should be followed in all hospitals. Pre-operative recording, including the provisional diagnosis, should be complete for all elective surgical patients before the anesthetic is started. It is permissible to write an admission note and pre-operative diagnosis on bonafide emergency patients when to hold up the operation for the writing of the history and physical examination would be to their detriment.

■ PROBLEM: A superintendent writes that certain fire hazards exist in the operating room of her hospital, also that the trustees have arranged with a nearby, larger hospital to supply her institution with anesthetic service. Should the trustees ban certain explosive anesthetics until a hazard-free operating room is provided or should the anesthetist be permitted to assume responsibility for the selection and use of an explosive anesthetic under existing conditions? Are the trustees responsible for the anesthetist's acts?

■ ANSWER: In our opinion the board of trustees is ultimately responsible for the anesthetist's acts and for the anesthesia service, just as it is for the care of patients on the clinical services of the hospital. Assuming that the anesthetist supplied by the larger hospital is a qualified medical anesthesiologist, the board must delegate to him the responsibility for his department and the selection of anesthetics to fit the individual patient's needs because of his superior judgment and knowledge in that field, the same as it delegates responsibilities to other physicians and hospital personnel.

It is our opinion that the trustees should not ban certain anesthetics under the circumstances but should leave the matter to the judgment of the medical anesthesiologist.

In the event the anesthetist furnished by the larger hospital is not fully qualified in his field, direction of the anesthesia service in the writer's hospital should be assumed by a senior staff surgeon who has knowledge and experience in the field. The responsibility for the service would rest with the board of trustees if the surgeon undertakes supervision of the department.

July • 1952

hm

Hospital Management

The story of

The New York Hospital-Cornell Medical Center

■ THE NEW YORK HOSPITAL, which has cared for more than 3,700,000 patients during its 181-year history, was founded in 1771 by a charter granted during the reign of King George III of England.

Throughout its history, the hospital . . a voluntary hospital which does not operate for profit . . has adopted and furthered a fourfold concept of medicine:

1. **Care of the sick . .** To care for the sick, providing the same wisdom and skill to rich and poor.

2. **Teaching . .** The long affiliation of The New York Hospital and Cornell University Medical College expresses the hospital's time-tested philosophy that great medical institutions must provide for the teaching and training of new doctors, nurses and technicians for tomorrow as well as for the care of the sick today. The Cornell University-New York Hospital School of Nursing is one of the few whose courses can lead to a B.S. degree in nursing.

3. **Research . .** In every clinical and preclinical department of the institution, research probes constantly for new methods of diagnosis, new types of care and wider understanding of new drugs. The results of research in the early diagnosis of cancer, in chemotherapy, in high blood pressure, in arteriosclerosis and in psychosomatic medicine are examples of the activity which characterizes a well rounded hospital program.

4. **Preventive medicine . .** The hospital works constantly not only to cure sickness but to accelerate the development of new knowledge and methods of preventing sickness. Its concept of medicine is to prevent illness as well as to cure it.

Editor's note: This and the many succeeding pages in this issue devoted to The New York Hospital-Cornell Medical Center are not intended as a comprehensive story of the center but rather a story in summary form covering only a portion of the activities and achievements of this great medical and humanitarian institution.

Introduction . . .

I history

II activities

I

History . . In 1771 His Majesty, King George the Third, granted a charter to "The Society of the Hospital in the City of New York in America." Thus The New York Hospital, the first in New York and the second in the United States, was erected at Broadway and Pearl Street, New York City. The first patients cared for by the hospital erected under this royal charter were soldiers wounded in the Revolutionary War. Starting its service to the nation by thus serving in the conflict to establish the republic, The New York Hospital has made outstanding contributions in every war of our country's history.

Among the hospital's earliest progressive steps was its initial recognition that mental and nervous cases were curable and required medical care, not simple incarceration. It introduced vaccination for smallpox for the first time in New York; its board of governors ordered no distinction "in treatment or respect" between patients who paid and those who could not; it pioneered in the use of ether anesthetics; it cooperated in the establishment of America's first formal training school for nurses; it was the first hospital to introduce the use of temperature charts.

As the years advanced, the record lengthened . . new drugs, new techniques, new therapies, new facilities, new understanding. The latter years have been significant ones in which the hospital has taken the leadership in many important new programs including studies in psychosomatic medicine; in research to ascertain the causes of alcoholism, in the establishment of an ambulatory transfusion clinic for the treatment of serious blood conditions in children. The hospital has pioneered in a comprehensive medical care and teaching plan offering expanded services to individuals and families in the community, and in organizing weekly practitioners' conferences for non-staff doctors.

The society since its inception chose to maintain a teaching hospital, thus broadening its area of service far beyond its own community by assisting in the development and training of doctors and nurses who would take their new knowledge to the sick in all parts of the world. Thus, for example, it provided clinical instruction for medical students of Columbia College as early as 1791 and later provided educational facilities for Cornell University Medical College, the New York University Medical School and the College of Physicians and Surgeons.

The most significant date in the implementation of the society's teaching concept was 1912, when it entered into a formal affiliation with Cornell University Medical College. The hospital was then located just off downtown Fifth Avenue at 16th Street in a building completed in 1877 to replace the one occupied for 100 years on the first site in lower Manhattan. By 1927 the value of the association between the Hospital and Cornell had been so fully documented, and the potential benefits of a close permanent physical affiliation written so clearly, that it was determined to erect a new center in which their relationship could be further cemented for the benefit of the public they served.

Through an agreement between Cornell University and The Society of The New York Hospital a joint administrative board, composed of trustees and governors, was established to deal with the joint educational and therapeutic interests of The New York Hospital-Cornell Medical Center as a whole.

The school of nursing, established in 1877, was one of the first to be founded in the United States. The program and organization of the school have grown and changed to keep pace with the health needs of the society, and in 1942 by agreement between the trustees of Cornell University and the governors of The New York Hospital, the school of nursing was made a school within the University . . The Cornell University-New York Hospital School of Nursing.

The Hospital is operated by The Society of The New York Hospital through its board of governors, composed of 26 men and women who serve without pay. Through committees and board action, they formulate policies and approve decisions. It is the leadership of these men and women with courage and vision in the society and others like them, that contributed to the development of the high standards in medicine and surgery as practiced today at The New York Hospital-Cornell Medical Center.

The New York Hospital occupies with Cornell University Medical College and with the Cornell University-New York Hospital School of Nursing the 15 buildings, occupying three city blocks, of The New York Hospital-Cornell Medical Center at 68th Street and the East River, New York City. This center was occupied in 1932.

Three independently famous hospitals have in the course of years become affiliated with The New York Hospital and their operations consolidated with it. Thus, the Lying-In Hospital, founded in 1799, Manhattan Maternity & Dispensary and the New York Nursery &

Child's Hospital all form part of The New York Hospital clinics and departments operating in their respective fields. In 1947 these hospitals were legally merged into The Society of the New York Hospital.

In addition to its functions as a general hospital with an extensive outpatient department, The New York Hospital carries on special psychiatric activities in Payne Whitney Psychiatric Clinic in its own center and in The New York Hospital-Westchester Division at White Plains, New York. The latter division was known at its founding in 1821 as Bloomingdale Hospital, due to its location on Bloomingdale Road, now Broadway. Even prior to the establishment of Bloomingdale, The New York Hospital had a psychiatric department located in a separate building on its original site in lower Manhattan, the first separate psychiatric department in any hospital in the country.

II

Field of action . . Due to the extent, number and complexity of the professional projects being carried out at the center it is not possible to write in detail concerning the activities of all of the professional departments. The following information, therefore, can be regarded only as an outline of achievement.

The professional work of the hospital is divided among six major departments: medicine, obstetrics and gynecology, pediatrics, psychology, radiology and surgery. A full-time chief of the department is in charge of each of these services. The department of surgery includes eight surgical specialties: anesthesia, dental surgery, neurosurgery, opthalmology, orthopedics, otolaryngology, plastic surgery, and urology.

Attending physicians numbering 631 and 161 interns and residents provide the maximum of patient service, teaching and research at this center.

Clinical service . . Constant effort to extend the service of the medical center to the community has led to a number of significant developments in the organization of the hospital and in the operation of the outpatient department.

Consultation clinic . . To serve physicians of the community and to aid them in the solution of difficult problems among patients who cannot pay the full cost of diagnostic examination, a clinic has been established in the outpatient department to care for these patients. Only patients who are referred by their physicians are received in this facility. Examinations are searching, consultations with necessary specialists are convenient and prompt reports to the referring physicians are stressed. This clinic has aided materially in the establishment of closer relationships between the hospital and practitioners of the community.

To supplement this endeavor *practitioners' conferences* were initiated one year after the consultation clinic was organized. Established as a joint undertaking of The New York Hospital and the Cornell University Medical College, it was intended as a mechanism for presenting programs of special interest to the general practitioner, for affording opportunity for continuation and improvement of his training, and for sharing with him some of the advantages of this center. The conference is open to all physicians. A special invitation is extended to those having their offices in The New York Hospital district, to the many doctors who have referred some of their patients for consultation to the hospital or to members of its staff and to graduates of the Cornell University Medical College. With the help of the staff of the hospital effort has been made to discuss by panel problems of current interest as well as reviews of important subjects. By means of round table discussions the participating physician is enabled to ask questions and receive answers from the members of the panel. Emphasis is placed on thorough case study, important advances, common errors in diagnosis interpretation, and therapy. While diseases and groups of diseases in the various medical specialties are included, emphasis is on the functional pathology and origin of common symptoms.

Except during the hot summer months, the conferences are held every Wednesday from 5:15 to 6:45 in the auditorium of the medical college.

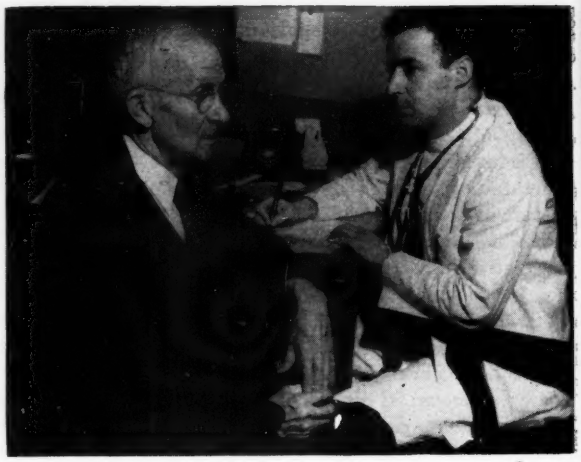
The care of children . . The department of pediatrics continues its original program of more comprehensive and continuing medical care for its patients. This program started with the pioneering premature unit and institute of child development, to a consideration of the emotional and social needs of normal children, and continuing with older children in the adolescent clinic.

Premature unit . . This unit was enlarged in 1948 to serve as a center for the admission, through the New York City Premature Transport Service, of premature infants born in other hospitals. In spite of the increasing number of infants in the smaller weight groups, mortality statistics show a satisfactory trend.

Institutes in the care of premature infants . . Institutes for physicians and nurses in the care of premature infants were started in 1949 with the aid of the New York State Department of Health and the United States Children's Bureau. These were designed to meet the needs of physician-nurse teams who are actively engaged in the management of a nursery for premature infants or in public health work connected with premature infant care. Many of the eastern and southern states have been represented. These institutes have been influential in spreading specialized knowledge about the care of premature infants and have contributed significantly to the establishment of centers for this purpose in many localities.

Institute of child development . . This institute has continued its emphasis on the emotional and social development of normal children, particularly as revealed in the behavior of the 2-to-3-year-old pupils of The New York Hospital Nursery School. It has also dealt with the emotional needs of hospitalized children. The Nursery School continues to be an important teaching

Inpatient A smile accompanies the work of capable personnel as inpatient care is given.



Outpatient Ambulatory patients and students alike benefit from the outpatient department.

mechanism in the indoctrination of doctors, nurses, medical students, occupational therapists, nutritionists, social service workers and patients in the normal personality development of children.

Psychosomatic clinic . . The psychosomatic clinic in the Department of Medicine was established four years ago to carry on investigations into more comprehensive form of diagnosis and treatment. During this period of its operation, approximately 2,000 patients have been seen by 19 physicians. The first objective of the project has been approximately achieved, namely to ascertain whether or not patients whose difficulties arise in the setting of stressful life situations can be managed successfully in an outpatient department, by properly qualified internists.

This psychosomatic enterprise has contributed significantly in the shaping of modern concepts of medicine. Disease is being considered more in terms of the host's adaptive processes to assaults of environment rather than damage done by the hostile forces themselves. Since the human organism has a limited number of ways in which it can react, almost identical adaptive processes may be set up in response to a variety of threats. Such reactions, at first essentially functional, may themselves lead to tissue damage and structural abnormalities when they have been unduly sustained or severe. Finally the studies have indicated that processes of disease may be initiated by stresses arising from personal adjustment to life situations as truly as from the stresses of burns, injuries or parasitic invaders.

Vincent Astor diagnostic service . . This enterprise was established by members of the staff at the beginning of 1950. Its purpose is to serve ambulant patients who can pay full hospitalization and prefer to obtain necessary diagnostic tests without complete interruption of their occupations. It provides a facility where physicians of the community can find aid in the solution of difficult diagnostic problems and convenient arrangements for consultation with members of the staff. During the first year of operation both the number of patients admitted and the number of outside physicians using the facilities have increased. One hundred fourteen members of The New York Hospital staff have participated in this service.

Rehabilitation clinic . . As an aftermath of the poliomyelitis epidemic of 1949 a clinic for the after care of infantile paralysis was established through the cooperation of orthopedists, physiotherapists, internists and social service workers. This formed a nucleus for an interdepartmental rehabilitation conference, in which problems of convalescence and rehabilitation of patients on all hospital services could be discussed. The need for such a program developed rapidly and a committee on social and vocational restoration was appointed in March 1950, consisting of representatives of the departments of medicine, nursing, occupational therapy and social service and the New York State Education Department, division of vocational rehabilitation.

Since its appointment, the committee has studied the problems of some 60 patients exhibiting 35 different categories of disease, with respect to the social and vocational aspects of patient care. The interest, understanding and cooperation of the members of this committee have aided greatly in the restoration of many chronically ill and crippled patients to lives of usefulness.

Clinic for comprehensive medical care and teaching program . . One of the most significant developments in ambulatory care was the establishment on July 1, 1951 of the comprehensive medical care and teaching programs made possible by a generous grant to The New York Hospital-Cornell Medical Center by the Commonwealth Fund.

The outpatient department is the focal point of this program, the purposes of which are:

Clinic Social and vocational restoration problems are aired in committee meetings.

O. T. Little hands receive direction from volunteers in occupational therapy department.

To foster the improvement of methods applicable both to individuals and families.

To afford opportunity to undergraduate and graduate students of medicine, nurses and social workers to participate in more comprehensive care under the guidance of experienced physicians.

To accomplish more complete integration between clinical departments.

To develop closer relations between the center and the community and to record and analyze over a period of years the medical and sociological assets of the plan as well as its feasibility for more general application.

Postoperative recovery unit . . The postoperative recovery unit provides the constant and expert care so necessary in the period following operative procedure and anesthesia. This unit has added immeasurably to the safety of patients who have undergone the extensive operations so frequent in present practice.

Rooming-in plan . . By means of the rooming-in plan, by which the mother and her new-born baby are cared for in the same space unit, mothers may learn by observation and practice the principles and many details of infant care. At the same time nurses may more easily teach mothers and learn from them.

Early rising following delivery has been continued and with the use of antibiotic therapy has made it possible for patients to leave the Hospital earlier than heretofore. Experience has indicated that the postpartum and postoperative hospitalized period is pleasanter and is associated with less discomfort and with fewer complications than were encountered when patients were confined to bed for a major portion of their hospitalization.

Ambulatory care . . A significant development of the past few decades in the field of hospital service has been the steadily increasing emphasis on ambulatory care in clinics and doctors' offices as contrasted with inpatient care. Factors supporting this trend are: the ever increasing cost of inpatient care, the fact that more and more diagnostic and therapeutic procedures can be performed on an ambulatory basis, the fact that most patients prefer to continue if possible in their normal pattern of living while undergoing diagnostic studies and treatment, and the need and desire of wage-earners to avoid a loss of income resulting from hospitalization. The increase in the utilization of the hospital's diagnostic services suggests a growth in the number and complexity of difficult diagnostic problems presented by outpatients.

A broad program for the improvement and expansion of ambulatory services for patients of all income levels has been under development for the past several years. During 1951 considerable progress was made in the implementation of this program, the objectives of which are to make the facilities of this medical center more widely available.

The outpatient department services are constantly under study in the effort to extend the benefits of the center into the community through a variety of means all of which contribute to the improvement of ambulatory services to patients and to the further development of cooperative relationships with physicians of the community.

Research . . Investigation, made possible by numerous gifts and subsidies from individuals, foundations, corporations and federal agencies, occupies a large part of the energies of the clinicians and teachers of the staff.

The extent as well as the variety of the investigative projects now being conducted in The New York Hospital can perhaps be best appreciated by simple listing. Although most of them represent departmental activities, many are interdepartmental in scope, while others depend upon the cooperation and incidental and continuing aid of two or more departments. For this reason the projects are grouped under subject headings. Extensive as

O. R. The heart of the hospital beats with skilled hands at work 'round the clock.

it is, the list is not inclusive, since it omits many tentative explorations which may form the basis for important future investigations:

Diseases of the circulation.

Diseases of the urinary tract.

Infectious diseases and chemotherapy.

Cancer.

Diseases of the blood.

Diseases of the stomach and intestines.

Metabolism and endocrinology.

Allergy.

Diseases of the skin.

Pregnancy and diseases of women.

Premature infants.

Diseases of the nervous system and psychosomatic disorders.

Psychiatric diseases.

Taken as a whole the list presents an extraordinary range of interest and accomplishment in which every department has participated. Although most, if not all, of these projects merit special discussion, only a few trends and outstanding contributions will be mentioned.

That great emphasis has been placed upon cardiovascular diseases is evident. Significant progress has been made in the investigations on the influence of chemical substances of hepatic and renal origin, upon the pathogenesis of shock, high blood pressure and other circulatory disorders. Both in the departments of medicine and pathology, important disclosures have been made concerning chemical factors in arteriosclerosis. The resources of several departments have been combined to encourage research in the visualization and catheterization of blood vessels. There has been intensive investigation of clotting mechanisms and of procedures for the prevention and control of thrombosis and embolism. Both in the laboratory and in the clinic, the department of surgery has focused attention upon methods for the surgical treatment of diseases of the heart and blood vessels.

The establishment of laboratories for surgical research has encouraged investigation of water and electrolyte balance in renal, hepatic and nutritional diseases. It has advanced the studies of hepatic function in portal hypertension and other circulatory disturbances of the liver. It has aided the development of new procedures in the surgery of the spleen, liver and heart.

The rapid growth and productiveness of the laboratories for bacteriology and immunology in medicine is notable. Last year their program was extended to include a station on the second (Cornell) medical division at Bellevue Hospital. In 1951 the laboratories cooperated with the Public Health Service in studies of epidemics in distant parts of the country, an activity which may be regarded as a tribute to their unique features and as increasing recognition of their general usefulness.

A gratifying development during 1951 was the action by friends of the Hospital to form a fund for study of diseases of the muscles with special emphasis on muscular dystrophy. This successful enterprise, which operates under the name of the "Muscular Dystrophy Associations of America, Inc.," has been crucially important in maintaining and extending significant investigations on the pathogenesis and treatment of muscular disorders.

Graduate education . . In a typical year, approximately 41 interns, 129 residents and 34 resident fellows receive graduate training at The New York Hospital. This program represents an outstanding contribution to medical education and constitutes one of the most important activities of the Hospital. It is, however, only one part of the influence exerted in the training of graduate students. Each year, physicians from many parts of the United States and numerous foreign countries attend the conferences and remain as observers for periods varying from a few days to many months.

Administration . . departments services programs

■ THE ENTIRE ADMINISTRATIVE STAFF is thoroughly indoctrinated with the attitude that it exists for one reason only: to further the best interests of the patient through the provision of all necessary services and facilities to permit the professional staff to prosecute its program of patient care, education and research in the most effective manner possible.

The administrative organization is based on recognized organizational principles of line and staff functions. The director is responsible to the board of governors for the operation of the hospital as a whole. His administrative staff consists of eight individuals who are responsible to him for the activities of the departments falling under their jurisdictions and who form the Administrative Advisory Committee through which staff functions are accomplished.

Each department head meets regularly with the member of the administrative advisory committee under whose jurisdiction his department falls, for the purpose of discussion of problems of policy, suggestions for improved production, employe relationships, etc.

In an effort to coordinate more closely the activities of the clinical, nursing and administrative staffs, there have been developed within the past year administrative advisory committees for the different clinical services. Each committee is chaired by a member of the director's administrative staff and includes in its membership the chief of the clinical service or his deputy, the chief resident for that service and the nursing department head. When the agenda for one of the monthly meetings includes a subject pertaining to any of the many administrative departments, the department head involved is invited to participate in the deliberations. In this manner the solution of many vexing problems of an administrative nature are arrived at and recommendations for necessary action are brought by the chairman to the administrative advisory committee.

Conference method . . The conference method is used extensively in reaching administrative decisions and establishing policies. It has been found that the participation of all responsible personnel in arriving at solutions to problems through the dynamics of the conference method has resulted in increased job satisfaction for all employes in sounder solutions.

Continued emphasis is placed on studies and efforts aimed towards the alleviation of the recurrent shortage of nurses and on the continuation of gradual adjustments to changing trends in hospital economics due in part to the impact of inflation, to the growth of voluntary hospital and medical care insurance plans and to increasing emphasis on ambulatory care.

Inflation and hospital costs . . With the release of price controls on July 1, 1946, the cost of commodities and services began to increase and, with minor exceptions, has continued to increase steadily ever since. This is reflected in the Department of Labor's cost of living index, which for New York City stood at 154.6 in January 1947 and 182.5 in September 1951, a rise of 18.0 per cent in approximately five years. During the same period operating cost of ten representative United Hospital Fund general hospitals for which figures are reported regularly every quarter, increased by 32.0 per cent for the first nine months of 1951 over the year 1947. The increase for The New York Hospital was 22.5 per cent.

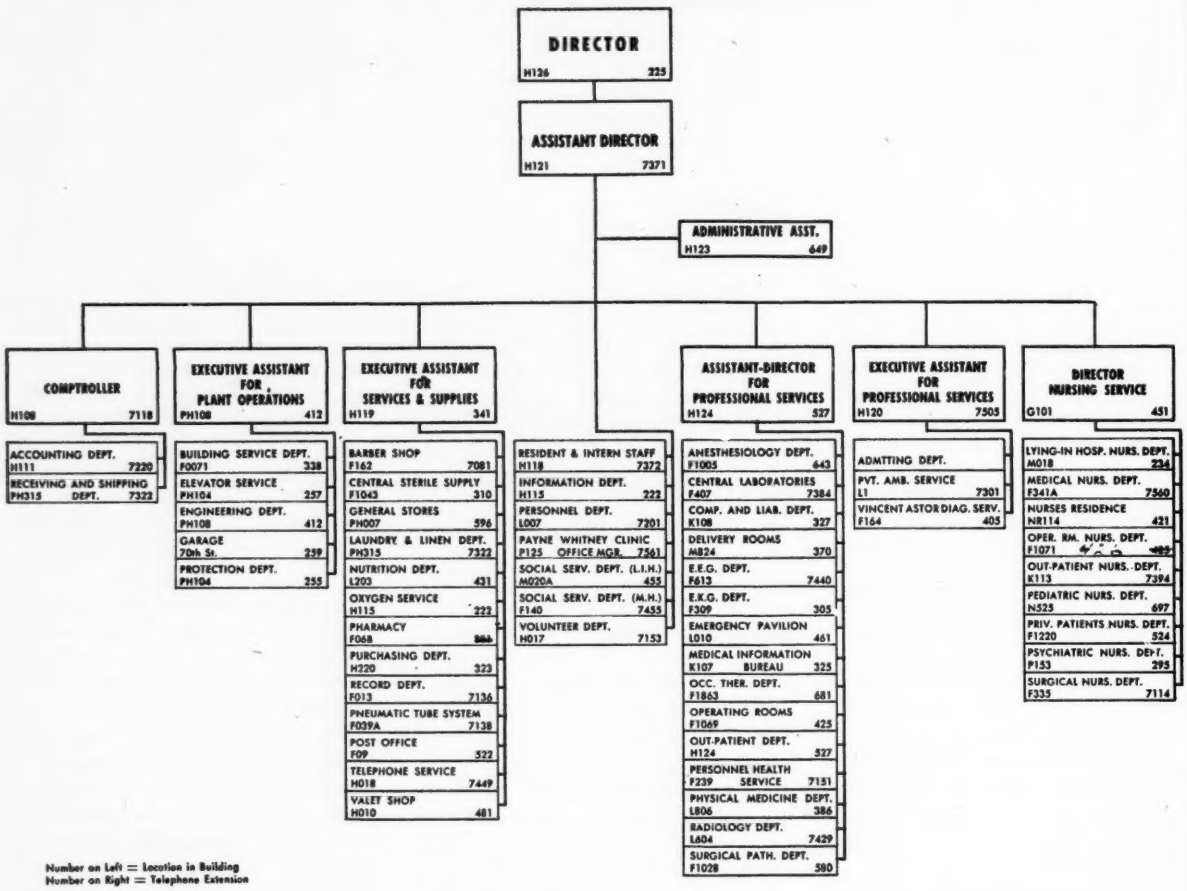
It is of interest to note that hospital costs have risen more rapidly than has the cost of living index. Some of the factors other than general economic trends operating to increase hospital costs are: the introduction of new and expensive drugs; the rise in the use of laboratory, x-ray and other diagnostic procedures; the increasing complexity of surgical operations and the attending necessity to correct chemical imbalance in the body's metabolism through the administration of whole blood, plasma and various electrolytes.

These are desirable developments in that they improve the health of outpatients and tend to shorten their hospital stay. They are, however, expensive. These medical advances have resulted in the necessity of supplying more hours of nursing care, more technicians, more medical record librarians, more sterile supply workers, more laundry workers, more medical and surgical supplies, more linen.

In fact, there is hardly a hospital department that does not feel the impact of a changing medical technology. A simple illustration dramatically emphasized this change: approximately 3,000 hypodermic needles per day are now required at The New York Hospital to obtain blood and other specimens for diagnosis and to administer therapeutic substances.

Industry applies a brake to rising costs by continuously increasing the productivity of the individual through mechanization, whereas hospitals, which provide largely personal services, become increasingly expensive as medical technology becomes more complex and requires more and more personal

THE NEW YORK HOSPITAL
CHART OF ADMINISTRATIVE ORGANIZATION


DIRECTOR
H136 225
ASSISTANT DIRECTOR
H121 7371
ADMINISTRATIVE ASST.
H123 649
COMPTROLLER
H108 7118
ACCOUNTING DEPT. H111 7220
RECEIVING AND SHIPPING DEPT. PH315 7323
EXECUTIVE ASSISTANT FOR PLANT OPERATIONS
PH108 412
BUILDING SERVICE DEPT. F0071 338
ELEVATOR SERVICE PH104 257
ENGINEERING DEPT. PH108 412
GARAGE 70th St. 259
PROTECTION DEPT. PH104 255
EXECUTIVE ASSISTANT FOR SERVICES & SUPPLIES
H119 341
BARBER SHOP F162 7081
CENTRAL STERILE SUPPLY F1043 310
GENERAL STORES PH007 596
LAUNDRY & LINEN DEPT. PH315 7332
NUTRITION DEPT. L203 431
OXYGEN SERVICE H115 222
PHARMACY F068
PURCHASING DEPT. H220 323
RECORD DEPT. F013 7136
PNEUMATIC TUBE SYSTEM F039A 7138
POST OFFICE F09 322
TELEPHONE SERVICE H018 7449
VALET SHOP H010 481
RESIDENT & INTERN STAFF H118 7372
INFORMATION DEPT. H115 222
PERSONNEL DEPT. L007 7201
PAYNE WHITNEY CLINIC P125 OFFICE MGR. 7561
SOCIAL SERV. DEPT. (L.I.H.) M020A 435
SOCIAL SERV. DEPT. (M.H.) F140 7455
VOLUNTEER DEPT. H017 7153
ASSISTANT-DIRECTOR FOR PROFESSIONAL SERVICES
H124 527
ANESTHESIOLOGY DEPT. F1005 643
CENTRAL LABORATORIES F407 7384
COMP. AND LIAB. DEPT. K108 327
DELIVERY ROOMS M824 370
E.E.G. DEPT. F613 7440
E.K.G. DEPT. F309 305
EMERGENCY PAVILION L010 461
MEDICAL INFORMATION K107 BUREAU 325
OCC. THER. DEPT. F1863 681
OPERATING ROOMS F1069 425
OUT-PATIENT DEPT. H124 327
PERSONNEL HEALTH F239 SERVICE 7151
PHYSICAL MEDICINE DEPT. L806 386
RADIOLOGY DEPT. L604 7429
SURGICAL PATH. DEPT. F1028 580
EXECUTIVE ASSISTANT FOR PROFESSIONAL SERVICES
H120 7505
ADMITTING DEPT.
PVT. AMB. SERVICE L1 7301
VINCENT ASTOR DIAG. SERV. F164 405
DIRECTOR NURSING SERVICE
G101 451
LYING-IN HOSP. NURS. DEPT. M018 234
MEDICAL NURS. DEPT. F341A 7560
NURSES RESIDENCE NR114 421
OPER. RM. NURS. DEPT. F1071
OUT-PATIENT NURS. DEPT. K113 7394
PEDIATRIC NURS. DEPT. N525 697
PRIV. PATIENTS NURS. DEPT. F1220 524
PSYCHIATRIC NURS. DEPT. P153 295
SURGICAL NURS. DEPT. F335 7114

Number on Left = Location in Building
Number on Right = Telephone Extension

service for its application. For industry the labor cost becomes an ever smaller percentage of the total cost of the unit product; for hospital the labor cost becomes an ever greater percentage of the total cost of providing a day of patient care.

Cost rise . . Hospital costs have risen faster than the cost of living index also because hospitals have lagged behind industry in shortening the work-week of their employes and in raising wages and salaries. During the past few years of prosperity and high employment hospitals have found it necessary to reduce working hours and to raise salaries in order to compete with industry in the recruitment of employes. This has resulted in increased costs out of proportion to the general rise in industry.

As a result of these rising costs, philanthropic dollars, both as income from endowment and current gifts, often are insufficient to pay for the free care provided to medically indigent patients in wards and outpatient departments.

This trend can be illustrated by reviewing briefly the experience of The New York Hospital. In 1946 the difference between the cost of providing care in the pavilions (wards) and outpatient department and the amount paid for this care by the patients or by third parties on their behalf (i.e., free care) totaled $1,530,000 exclusive of depreciation as a part of cost. Investment income and current gifts, including the United Hospital Fund contribution, amounted to $1,350,000.

To balance the 1946 budget, excluding depreciation as a cost, there remained the need for only $180,000 additional income, much of which

The New York Hospital in terms of figures

Number of beds, The New York Hospital	1,208
Westchester Division	301
Laboratory examinations	483,302
X-ray examinations	80,288
X-ray treatments	10,107
Number of operations	14,664
Number of deliveries	4,272
Number of Electrocardiograms	18,987
Physical therapy treatments	25,664
Transfusions	9,652
Pharmacy prescriptions	149,022
Meals served	2,909,224
Record room	
New case records indexed and filed	29,715
Circulations	795,794
Laundry — pounds	5,402,147
Employes	2,796

could be derived through the private, semi-private and private ambulatory services. In 1951, however, free care had risen to $2,830,000 and income from endowment and current gifts to $1,460,000, leaving a gap of $1,370,000 to be filled by income from other services or by an appropriation from capital. Philanthropy appears, for the present at least, to be unable to close the gap.

Accounting department

■ UNDER THE BY-LAWS of The Society of The New York Hospital, the comptroller "shall be under the supervision of the director of the Hospital in the conduct of the general business of the society, but his ultimate responsibility in regard to accounting matters shall be directly to the governors."

He and his accounting department staff of 63 are responsible for maintaining adequate records of all assets, liabilities and financial transactions of The Society, for installing and maintaining proper internal auditing procedures, for seeing that adequate audits are regularly made, and, in conjunction with the officers, for initiating measures and procedures whereby the business activities of The Society shall be conducted with the maximum safety, efficiency, and economy. Changing techniques in medical care and the higher cost of hospitalization make these responsibilities far from static ones.

In fulfilling these tasks, the accounting department is called upon for such financial written reports as statistical data for the annual report; monthly balance sheets, operating statements for the Hospital and all its divisions, budget comparisons, quarterly cost statements, and statements on additions to and sales of equipment. It prepares the operating budget of The Society in cooperation with department heads and the director of the Hospital for submission to the board of governors, and also prepares periodic reports for departments on comparisons of budgets with actual results.

Seven sections . . The accounting department is divided into seven sections whose work is coordinated by intra-department duties. These sections are the comptroller's office itself, general accounting, patients' accounts, manager of accounts office, auditing, payroll, and outpatient department cashiers. In addition, the comptroller has ultimate responsibility for the four-man receiving and shipping department.

General accounting, with a staff of 13, is responsible for the maintenance of all general accounting books, including payable, general ledger, equipment ledger and fiduciary accounts. It pays all the Hospital's bills, a job that involves the issuance of about 2,000 checks per month. It is in this section that the work of preparing the operating budget of the Hospital is done, as well as cost statements and all financial reports for government and other outside agencies.

While other sections of accounting operate on a five-day week, patients' accounts must, by the nature of its work, be a seven-day-a-week operation; it is open from 8 a.m. to midnight. This section records all patients' charges and submits weekly bills to those responsible for payment. All bills are prepared initially on the basis of Hospital charges for services rendered without regard to contractual arrangements such as Blue Cross, etc. The daily postings run about 1,200. Work in patients' accounts has its public relations aspects, too, since this is where the patient may receive a final explanation of charges when he picks up his bill prior to payment.

Vital section . . One of the most vital sections of the accounting department is the manager of accounts office whose responsibilities include the follow-up of patients' accounts to their ultimate disposition. The functions of this section were augmented in 1951 when it took over the duties of the former compensation and liability department.

This change was instituted so that the follow-up of all types of patients' accounts could be integrated including the follow-up of outpatient department charges. The change has brought about a more effective control of accounts and, at the same time, it has resulted in better service to the patient since all aspects of the account can be discussed in one office, regardless of whether the patient is solely responsible for his bill or whether it is wholly or partially the responsibility of a third party.

The work of this office has increased and continues to grow as the result of the spread of health insurance coverage. Six of the ten members of this office work exclusively with Blue Cross and commercial health, accident and liability insurance companies. Working closely with the medical information department, described elsewhere in this article, the manager of accounts office clears the financial aspects of any information about a patient going to lawyers, insurance companies, the courts, etc., to protect the Hospital's financial interests.

The internal auditing staff of six is responsible for the audit of all accounting and cash records of The Society, including those of the Westchester Division and for the institution of systems to safeguard the assets of The Society. The auditors also help with the preparation of plant equipment records and statements on real estate income of The Society, and assist affiliate units of the Hospital such as the Alumnae Association of the school of nursing with the audit of their books.

C.P.A. . . In addition to the Hospital auditors, independent certified public accountants are at work checking the policies and procedures of the entire Hospital and the operating efficiency of the accounting department. The work of everyone in accounting is subject to yearly audit.

During the last ten years, the work of the payroll section has increased tremendously because of the increase in the number of deductions on employes' salaries. In 1951, for example, social security coverage was extended to all Hospital employes; in addition, the revised tax status of the house staff resulted in the addition of these men and women to the regular payroll, and the program of weekly payments for employes was extended to include graduate nurses.

Consequently, the payroll section prepares about 3,000 pay checks a week, faced not only with watching for social security deductions but also further subtractions such as state taxes on out-of-state residents, Government bond purchases, and rental of rooms, and such additions as overtime and night and evening bonuses for graduate nurses.

There are four paydays weekly, checks being distributed and cashed for the various departments on specified days. Since the meal ticket system was abolished several years ago, student nurses have been receiving a cash allowance, issued through the payroll section, every two weeks instead.

Collecting and recording fees charged to outpatients and originating information required in connection with outpatient department statistics are the chief responsibilities of the five outpatient department cashiers. But they also are "Information Please" experts, offering sympathy, advice, transportation directions and answering a steady barrage of questions.

Medical information department

■ ONE OF THE HOSPITAL'S smallest and youngest but most vital departments is medical information. Established in January, 1949, its work of furnishing medical information about patients upon request of insurance companies, employers, lawyers and referring physicians has developed rapidly. In its peak year to date, this seven-woman department received over 42,500 requests for information and wrote more than 13,000 letters.

Establishment of the department has been part of an over-all plan to enlarge the scope of the Hospital's service to the community, to develop more harmonious relationships with doctors and other hospitals in the Greater New York area and outlying areas so that the Hospital can better serve them and their patients, to build rapport with business firms, insurance companies, welfare agencies.

Medical records . . files in The New York Hospital

Before medical information was set up as a separate department, its work was "farmed out" to various other departments. One of its most important functions has been to take the burden away from the busy doctors who previously had to take time to fill out requested forms. Now members of the department, all experts in analyzing and correlating charts and records, transmit the necessary information to the agencies requesting it. A letter or an official Hospital report form is used, either being signed by one of our medical officers.

Social service department

■ EVERY DAY, many patients from the pavilions or the outpatient clinics are referred to the 31 medical and psychiatric social workers of the Hospital for help with environmental and personal problems related to their illness. Some of the patients seek help themselves and others are referred by members of their families or friends, but the majority are referred by the medical staff, who recognize that the most expert care may be ineffective if the patient is unable to carry out medical recommendations or to accept the limitations of his illness.

Modern hospital care is characterized both by the understanding that social and medical factors are inextricably interrelated and that treatment is a team-work process in which all of the professional personnel are concerned. Thus social service functions as an integral part of patient care and the social worker plans jointly with the physician and the patient to the end that the patient may become well and stay well or live as satisfying an existence as possible despite his physical handicaps. Social service is available to any patient of the Hospital, whether he is a private, semi-private or pavilion patient, and is continued as long as the joint medical and social need exists.

The assistance of the social worker may range from giving concrete suggestions for dealing with simple problems such as arranging for convalescent care or obtaining surgical appliances to helping with less tangible difficulties which impede recovery. These may be attitudes of the patient toward chronic invalidism, distress over disfiguring handicaps or anxieties rising from unsatisfactory family or work relationships. The worker provides an opportunity for the patient to talk over his difficulties with her and offers understanding, support and encouragement in planning.

Put back on feet . . One of the patients when asked by a doctor what the social worker had done for him said, "She tried to get me back on my feet." He did not mean this literally because he had no feet, or legs.

This patient was an intelligent unmarried man in his early forties, living with and supporting his elderly mother. He was a printer by trade with a small shop of his own. When referred by the doctor he was dazed over the prospect of a life of complete disability. In helping "to get him back on his feet" the social worker had two jobs, one to bring to his assistance all of the community resources which were available and the other to give assurance and encouragement to this patient who faced obstacles which needed more than his own store of courage and perseverance to overcome. A referral was made to the State Department of Vocational Rehabilitation for artificial limbs and when they were decided to be impractical, for a special wheel chair which he could raise and lower at his work.

Both private and public agencies were contacted so that he and his mother might have help during his rehabilitation period, so he would not lose his shop with its expensive equipment and so materials would be available when he was ready to start work. More than a year of continuous casework went into trying to solve this patient's environmental problem and helping to meet with understanding and support the anxieties and discouragements which were inevitable with such complicated plans. He returned to his printing business and is now living a self-suporting and satisfying life despite his disability.

Gift shop

■ FROM A HUMBLE BEGINNING on borrowed capital in the Fall of 1932 which was paid back within a year, the Gift Shop has grown into an important special service of the Hospital to patients, visitors, and staff.

Conducted for the benefit of the social service department, the Gift Shop stocks newspapers, magazines, stationery, books, candy, greeting cards, tobacco, cosmetics, toilet articles, and an extensive variety of gifts ranging from jewelry to toys. Patients may rent radios and television sets through the Gift Shop, too. In addition to telephoning their orders to the shop, patients have an opportunity to do bedside shopping. Four carts, laden with assorted items, are wheeled through the inpatient areas daily. Patients are delighted with this opportunity.

When the Gift Shop was opened, its location was a 100-foot-square space, and the cash box and ledger had to be taken home by one of the two staff members. Today, the shop has a selling area of 500 square feet, plus a small rear office; there is a business office on another floor and a storeroom in the basement for stock, wrapping, mailing and loading the carts. The Gift Shop now has a staff of nine, headed by a director, plus a part-time employe who delivers newspapers to the floors on weekends.

Plant operations division

■ THE PLANT OPERATIONS division, which includes the engineering, building service and protection departments, elevator service and garage, are under the supervision of an executive assistant to the hospital director. A professional engineer, he also serves as head of the engineering department; other departments under plant operations have their own chiefs.

Coordination of this division from above is provided by the twice weekly meetings of the administrative advisory committee, of which the hospital director is chairman.

In his job of coordinating the work of the various departments under him, the executive assistant makes daily rounds of the power house, where all departments except building service have their headquarters, and of the Hospital. Once a month, he presides at a meeting of the advisory committee on maintenance, which includes representatives from various departments under plant operations, the executive assistant for services and supplies, purchasing, nursing, public relations, laundry and linen service, and the director of the nurses' residence.

Among the diverse maintenance matters discussed at these meetings are cleaning and painting schedules, standardization of equipment and supplies, lighting problems, the purchase of new furniture and drapery fabrics. No work outside of routine maintenance jobs is done without the approval of the Hospital director, and he may appoint special committees for major projects such as the current reconstruction of nurses' locker rooms.

Engineering department . . The engineering department, which the executive assistant for plant operations also heads, has two distinct sections . . the power plant and building maintenance. With their widely varied responsibilities, they make the power house the most interesting non-medical area of the hospital.

The *power plant,* which generates the center's steam and electricity, is one of the largest "isolated" power plants in New York City. Only gas is purchased from the public utility. The four boilers are capable of producing 200,000 lbs. of steam per hour; the plant produces about 11,724,000 kilowatt hours of electricity annually. Thirty-five men . . operating engineers, oilers and firemen . . keep the plant going around the clock.

Under the building maintenance section there are a machine shop, upholstery shop, carpenters, plumbers, electricians, ventilating system mechanics, painters, elevator mechanics, a locksmith, masons, street cleaners, and a gardener. More than 55,000 work orders for repairs are completed annually by the engineering department.

Keeping 5,000 motors humming and 31,500 steam valves in working order is an impressive job in itself, but the five-man machine shop, while primarily a repair shop, also maintains all laundry equipment and does development work on machines that can't be purchased commercially. One of the shop's "originals" is a rubber glove testing machine for the central sterile supply department.

All mattresses and all upholstered furniture are reconditioned in the upholstery shop, which has a staff of five. Upholstery repairs are coordinated with cabinet and paint work on the furniture done by the carpenters and painters. The Hospital's furniture has been kept in such excellent shape that much of it on hand when the center was opened 20 years ago is still in use.

The eight carpenters are kept busy on minor construction work, cabinet making, floor repairs and woodwork maintenance. On minor construction work done by the hospital staff, masons, carpenters, plumbers, painters and electricians work together under their respective foremen. Coordination is provided by the chief carpenter. Major construction work is contracted.

With 8,400 fixtures and 110 miles of plumbing piping to keep in working order, the Hospital's crew of ten plumbers keeps going at top speed. A major project facing the plumbers now is the gradual replacement of steam return pipes which are wearing out after 20 years of service.

The chief duty of the 17 electricians in the department is to operate and maintain the electrical distribution system of the hospital with its 940 miles of electrical wiring.

Five mechanics care for the hospital ventilating system, maintaining its 20 miles of air ducts, 149 electric ventilating fans and 230 fan heaters as well as the air conditioning units in the 17 operating rooms and in several other areas. A staff of six mechanics keeps the elevators in condition.

Painting is another full-time activity at the center with its six miles of corridor walls, more than 40 inpatient units, 9,200 doors, and 8,103 window frames. Patient areas are painted about every two years. The

Control room . . in The New York Hospital is the key point in a network of power

force of 18 men in white overalls will be busier than ever now that it has been decided to paint all walls in patients' rooms various pastel shades instead of the traditional cream color. Head nurses have a choice of four colors to choose from as "facelifting" on the floors gets under way. When the interior of the main entrance on East 68th Street was painted recently, the painters had to climb a 32-foot scaffold to reach the highest paint point; they used about 80 gallons of paint on the job.

Other members of engineering charged with building maintenance include the locksmith who installs new locks to meet various security needs, makes new keys and spends a good deal of time in helping employes who have forgotten the keys to their desks; three streetmen who keep the grounds clean . . and that includes snow shoveling . . and a gardener, who does an amazing solo job of keeping the extensive lawns and gardens well manicured.

Building service . . The building service department has complete responsibility for keeping the Hospital spick and span. It is the largest department under plant operations. Several years ago the department's duties were enlarged when all cleaning and cleaning-maintenance responsibilities on inpatient floors were placed under its jurisdiction as part of the over-all plan to relieve the nursing service of non-nursing functions and to give the service departments a share in patient care. Until that time the line of demarcation between the responsibilities

of nursing and building service on cleaning varied among different nursing units.

Six executive housekeepers are assigned responsibilities for the various medical services and the nurses' residence. Each has a group of about 30 maids and houseman, whom they supervise on routine cleaning tasks. Each housekeeping unit is semi-autonomous, the housekeeper being responsible for ordering her own supplies and assigning her staff to their duties. She, in turn, is responsible to the director of building service. Payne Whitney Clinic and the Medical College have separate housekeeping staffs.

In addition, the building service staff includes floor polishers, marble floor cleaners, wall washers and several other categories of helpers who are assigned to duty from the building service office. Each of the three shifts of men, who perform these duties on a round-the-clock basis, has a foreman. In all, the building service staff totals 252 men and women who maintain this constant service seven days a week.

Among the never-ending operations of the department are wall washing and floor polishing, which go on both day and night.

But the department's responsibilities do not end here. It also does small maintenance jobs not requiring skilled engineering department mechanics, such as installing and servicing coasters, glides and bumpers on movable furniture and equipment. With the accent on preventive maintenance, the staff is instructed to watch for impending breakdowns of equipment. Building service does all the Hospital's moving; it helps the receiving department with deliveries; it washes and repairs venetian blinds and shades; it distributes and services special nursing equipment such as oscillating beds and air pressure mattresses; it fills and repairs soap dispensers in the washrooms. Building service is responsible for cleaning everything in the operating rooms except instruments. Windows are cleaned by outside contractors and then under the department's supervision.

One of the department's proudest accomplishments is its ability to shut down each patient unit for thorough cleaning once a year and reopen it for use within a week. This cleaning is coordinated with painting and mechanical repairs done on the patient unit at the same time. This operation, of course, can be accomplished because there are unused floors where patients can be transferred during the housecleaning period.

Protection department . . A 47-man protection force keeps constant vigil over the Hospital. While protection of life and property and directing traffic on the Hospital's eight and one-third acres are its primary duties, the protection department does much more than that. One of its newest responsibilities is to pick up the Hospital's first mail from the post office each morning, making it possible for the Hospital mail service to make deliveries an hour earlier. Another important duty is maintaining the lost and found department. Articles, which range from overcoats and hats to gloves and umbrellas, are turned over to the social service department if left unclaimed for nine months. Parking space on the center's property is at a premium and through the protection department's efforts, each space on the private street extension of 68th street leading up to the main entrance has a turnover of about three cars per day. From 10 p.m. to 6 a.m., the protection department provides watchmen's service throughout the buildings and grounds. At night, over weekends, on holidays, the protection department takes over many duties for other departments. For example, storing and issuing pavilion patients' clothing which is kept in the Hospital valet shop, assisting in the delivery of oxygen to floors and guarding cars in the hospital garage.

Elevator service . . The elevator service is another important service within the plant operations division with a supervisor in charge of this operation under the executive assistant for plant operations. The Hospital has 23 elevators and a staff of 51 male operators to run them; the distaff side is not employed because the doors are hand-operated.

Garage . . A 220-car garage on East 70th street, owned and operated by the Hospital, provides hourly daytime and full-time parking service to members of the medical and nursing staff and other personnel at a nominal charge. Garage attendants are on duty around-the-clock. The Hospital has a small pickup truck for emergencies.

Purchasing department

■ THE PURCHASING DEPARTMENT is one of the most important doors to the Hospital organization. It swings in to welcome the ideas, products and services of others and swings out to secure the requirements needed for efficient economical operation.

Here, too, the concept of teamwork prevails, for complete cooperation, good will and mutual confidence between this department and all other departments, as well as with the suppliers, are absolutely essential to attain the Hospital's objectives. Whether it's a dozen pencils, an x-ray machine, or a carload of canned tomato juice, the purchasing department initiates, conducts and concludes all negotiations affecting purchases, prices, terms, delivery, etc.

Intermediate negotiations, communications and interviews may be carried on between other departments and suppliers, but all such contacts are conducted with the knowledge and approval of purchasing.

Roughly one-third of the annual amount expended by the Hospital represents expenditures required to purchase necessary supplies, materials, equipment and services. To handle these expenditures, the purchasing department fills an average of 20,000 requisitions yearly, representing about 30,000 items, and processes a yearly average of 10,000 purchase orders.

With a centralized purchasing system and its single responsibility for the act of procurement, waste and duplication are reduced. Standardization of requirements has brought economies in inventory since fewer varieties can be bought in larger and more economical quantities.

Essential in this centralized system of procurement is the purchase order. No goods will be accepted by the Hospital without a purchase order number. At the time that the order is processed, five copies are issued . . one for the vendor, one for accounting, one for receiving, one for the department requesting the purchase, and one working (follow-up) copy for purchasing. Every purchase order issued is registered by order number, and the supplier is recorded.

A perpetual inventory of purchases is maintained through a Kardex system. Requisitions for supplies, etc., are filed numerically by department and kept for seven years; capital equipment requisitions are retained permanently. Another system for efficiency is the use of Wheeldex files of suppliers, listing name, address and terms and other pertinent information.

Constantly exploring the market for new materials, new suppliers, new grades, better delivery and prices and standardization of materials, the purchasing agent and his staff interview salesmen regularly. Certain days are set aside for interviewing vendors of particular types of products such as drugs and chemicals. Our principle is not to buy less, or cheaper, but to get maximum ultimate value for every dollar of purchase expenditure.

In addition, the purchasing agent has supervision over the Hospital print shop, which produces about 443, or almost 87 per cent, of the regular Hospital forms, and about 150 to 200 special forms. This four-man operation boasts such equipment as an automatic letterpress which can make 5,000 impressions per hour and can print pages up to 12 x 18 inch size; an offset platemaking unit; three multilith presses; a hand-feed platen press; mimeograph machine; perforator; paper drill; paper cutter; folding machine, and a 100-section storage cabinet.

Laundry & linen department

■ EQUALING many a commercial laundry in production performance, the laundry of The New York Hospital washes about five and one-half million pounds of linen per year, or over one ton and a quarter each hour. The laundry is one division of the laundry and linen department, which, with a staff of 85, occupies two entire floors of the power house plus part of a third floor.

In addition to collecting, laundering and delivering all patient linens, the department launders the uniforms and personal linen of the nursing and house staff and of student nurses, the white coats of the attending staff and technicians, the uniforms of members of the auxiliary staff, building service, nutrition department and the vari-colored smocks worn by many other employes.

The laundry and linen department has charge of the repairing of all linens, a job for the seven-woman staff of the sewing room who also manufacture 72 different items such as non-standard rubber draw sheets, rubber aprons and special operating sheets, and drapes and window shades for all areas of the Hospital.

The making of sterile packs is a new operation being taken over by the department, this task formerly having been done by auxiliary staff workers assigned to the operating rooms.

The department is responsible for ordering all new and replacement linens through purchasing, and for the linen inventory. The linen inventory is taken once a year, the physical count of the 252 types of items in circulation taking three days. Linen minimums and maximums are maintained based on actual linen usage, and replacement is made on the basis of actual discard and increased usage.

Two laundry views . . in The New York Hospital, New York City

Assisting the director of the department in carrying out the duties listed here are an assistant director, an office manager and statistician who has charge of inventories, cost analysis, etc., a storekeeper for linens, another person in charge of manufacturing, and a secretarial staff. In addition, there are supervisors for the washroom, flatwork ironing, fancy ironing, the linen room, the sewing room, and garment exchange.

While the department generally operates on a five-day, 40-hour week, linen pickup on patient floors is a seven-day-a-week operation. Patient linen is picked up daily from 8 a.m. to 5 p.m., the soiled linen from each floor being transferred to central soiled linen rooms in the sub-basement through vertical chutes. From here, the linen is collected on electric trucks and taken by elevator to the laundry. Return delivery to the floors is manual at present, but in the near future the department hopes to mechanize delivery, too.

Most patient units have been set up on a standard linen basis which

is filled by the laundry each day. In the case of nursing and house staff linen, there is a regular schedule of pickup and return; fiberboard boxes marked with the room number of the staff member are used to transport both the clean and soiled linen. Other Hospital employes turn in soiled uniforms and pick up fresh ones at the garment exchange in the sub-basement.

Backbone of washroom operations are 11 washing machines, including five automatic ones which can each handle as many as 10 loads of 400 pounds each per day. These latter machines can be loaded and unloaded in a minute and one-half. Washing formulas are watched constantly to safeguard the health of the patient and to protect the linen.

In the flatwork section, there are four ironing machines, two of which can iron sheets at the combined rate of 14 per minute. Thirty-seven pressers are employed in the fancy ironing section to iron and finish uniforms.

Medical record department

■ THE MEDICAL RECORD DEPARTMENT is looked upon as a combination business office and reference library. Its business functions include the setting up and maintaining of indexes and files of patients cared for and the treatment given; the statistical analysis of the patient load per hospital day, month or year, and the reporting in various forms of the amount and kind of work the Hospital does.

As a reference library, the department correlates and classifies all the data which have been accumulated about a patient and makes these data available for various uses . . and many uses there are in an institution with extensive teaching and research activities.

To maintain the round-the-clock, 7-day a week service that the record department provides takes 66 full-time and eight part-time employes. Some 3,500 to 4,000 records are circulated daily, the bulk of the pulling of records being done by the midnight to 8 a.m. shift and the refiling by the 4:30 p.m. to midnight staff.

The earliest medical record, a book of inpatient admissions dated 1793, provides an interesting contrast to today's detailed charts.

Under today's unit system a history number is assigned to the patient on his first contact with the hospital and all subsequent history is recorded in one folder under this number regardless of the number of times he is admitted and regardless of the number of different departments he may have contacted. The data may include correspondence with the patient, social service reports, requests for insurance information, as well as his inpatient and outpatient records.

Each record is bound in a flexible manila folder so that it can be transported through the Hospital's pneumatic tube system. In addition to being filed by history number, each record is indexed by name according to the Russell Soundex System and inpatient records and some outpatients are also filed by diagnosis and operation for cross reference purposes.

Diseases and operations are indexed according to the Standard Nomenclature of Disease and Operations published by the American Medical Association. The pattern of the Nomenclature of Operations was carried over to a large extent from The New York Hospital Classified Nomenclature of Operations developed by Miss Helen R. Lincoln, R.R.L., head of the medical record department and Dr. Bronson Ray, attending surgeon, as an internal Hospital document in 1938.

One of the biggest jobs of the medical record department is statistical. Daily, monthly and yearly figures are provided on births, deaths, patient days, percentage of occupancy, admissions, discharges, transfers, etc.

Teaching tools . . Still another important function of the department is the preparation of records and statistics for teaching, research and for manuscripts being prepared by staff members for professional publications.

As a member of the Hospital team in patient care, the medical records department makes large contributions in simplifying the work of the many departments with which it works. For example, there are the clerical functions which it performs, such as supplying the floors with forms which would ordinarily have to be prepared by nursing personnel, routing forms and records to the floors for initiating and carrying out patient care as promptly and smoothly as possible.

At the time a patient is admitted, the record department makes up a metal addressograph plate with the patient's name and history number and runs off 14 different forms needed by the various departments of the Hospital at the time of admission. Along with this, it prepares a card for the floor's roster of patients. If a patient has had a previous admission, this old record is automatically sent to the floor.

Recently, in order to supply the floor with the patient's history number immediately, arrangements have been made for the admitting office to clear the name and secure from the record department the patient's history number which is entered on the assignment slip which goes to the floor with the patient. This helps in ordering emergency laboratory or other work-up requiring the patient's history number and voids the necessity for the nurse to call and get the patient's number.

To help relieve the nurse of "paper work" in heading up forms, filling out requisitions for laboratory, x-ray, charge slips, etc., the medical record department, after running off the 14 aforementioned forms, sends the addressograph plate to the floor for her use.

Teaching . . In addition to these multitudinous duties, the medical record department also has teaching responsibilities . . in orienting incoming interns and residents, medical and nursing students, staff nurses, x-ray technicians, dietitians, and others on record room procedures. In addition, all personnel of the department receive "on the

job" training in their work.

Since 1946, the department, in cooperation with the board of education, has used cooperative students from local high schools and given them training in various departmental duties. At present, 11 full-time positions are filled by girls who began their training this way.

With more than 795,000 records in circulation in an average year and close to 30,000 new patient records initiated each year, the problems of keeping track of them might seem complex. A system of charging out each record from its place in file solves that situation. The department has also developed an effective follow-up system for the completion of inpatient records.

First, a slip is attached to incomplete charts indicating items to be completed and querying doctors on various other matters. Then, lists of the incomplete charts are sent weekly to house staff and monthly to the Hospital director, the records committee and medical board. Dictaphones are available for use by doctors both day and night.

Central laboratories

■ CENTRAL LABORATORIES is a service organization, serving in one way or another all of the sections in the Hospital and some of the departments in the medical college and thus has widespread contact throughout the institution.

The functions of the central laboratories can most readily be presented under three headings: diagnostic laboratories, research and teaching.

The diagnostic laboratories consist of basal metabolism, bacteriology, chemistry, clinical laboratories, serology, T. B. diagnostic laboratories, parasitology, blood bank.

In these laboratories are carried out the great majority of the diagnostic laboratory examinations for the patients cared for in the hospital and outpatient department.

Basal metabolism, bacteriology, blood bank, chemistry and serology are all located on the fifth floor. These laboratories serve all clinical services of the Hospital for inpatients, outpatients and private ambulatory.

The clinical laboratories are distributed throughout the Hospital, being situated as close as possible to the clinical service which they serve. Some are located on medical clinic floors, some on surgical floor, others on semi-private and some on private floors.

Clinic patients go to the clinic laboratory to have blood specimens taken. Technicians for private and semi-private patients go to the bedside. Specimens for bacteriology, chemistry and serology and for transfusions are collected at the patient's bedside or in the clinics, and brought to the laboratories by messenger. Blood donors go directly to the blood bank to donate their blood. The T. B. and parasitology laboratories are located on the fourth floor and specimens are brought to these laboratories by messenger.

The blood bank is a very important unit of the laboratory and operates 24 hours per day, 7 days a week. Daily service is provided by the other laboratories and "on call" coverage for emergency is provided during the night. Transfusions are no longer given as emergency procedures only but are often used as therapy in many diseases.

When the Hospital moved from West 16th street to its present site, central laboratories was a very small service with about 25 members and had space only on the second, fourth, and fifth floors. The demands made upon this department have constantly increased from year to year so that it has now developed into a large, complex organization with a staff of more than 80 and occupies space on 12 different floors of the Hospital with headquarters on the fourth floor.

The largest volume of work is carried out on the fifth floor where the personnel consists of three physicians, a chemist, bacteriologist, serologist, hematologist, 55 technicians, 15 glassware washers, 3 clerks, 2 secretaries and one administrative assistant.

It may be of interest to note that in 1933, the annual report showed a total of 47,000 examinations done for that year. The annual report for the year ending 1951 shows a total of 405,634 examinations.

Active research is being carried out by several members of the staff. In addition to specific projects in research, the central laboratories directly and indirectly assist numerous members of the Hospital staff in the performance of clinical research.

Teaching is an important part of the work of central laboratories. It includes a course in clinical pathology to medical students in the second year, a class of between 75 and 80 students; a course in pathology to the student nurses in the school of nursing, a class of between 80 and 85; the supervision of the laboratory work of the clinical clerks (medical students) on the pavilions.

Pharmacy department

■ THE APOTHECARY OR PHARMACIST was designated as such in the original charter of the Hospital, and his duties were enumerated by the Board of Governors as early as 1790.

The function of the pharmacist now is as important and responsible as it was then . . only somewhat more specific. Today the pharmacists are no longer required to cover the maternity section and to take charge of uncomplicated deliveries during their on-call periods as they were in 1804; nor are they discharged, as was the first apothecary in 1774 because he absented himself from the hospital without permission from the Board of Governors, nor are the pharmacists today required to act as Hospital librarian or registrar, or to accompany the house surgeon on his rounds every

morning, as was done in the early 1800's.

This present specialization is obvious when we consider that the pharmacy department today comprises a total of 7,149 square feet of floor space as compared with 340 square feet considered adequate in 1804

The basic departmental organization is rather military in nature, with such sections as manufacturing and sterile supply laboratories, stock rooms and pre-packaging schedules in support of the front line, composed of the outpatient dispensary and the general dispensing unit whose personnel are periodically relieved by pharmacists from the other routines during daily periods of peak work load in a coordinated effort to achieve this symbolized objective.

The total departmental team is composed of 11 pharmacists, 5 helpers, 2 messengers, 1 technician, 2 departmental secretaries and a clerk-typist, whose primary duty is the processing of New York City Department of Welfare prescriptions in preparation for dispensing, and the maintenance of the necessary records as required by Welfare Department regulations.

The general manufacturing laboratory . . manned by two pharmacists and two helpers, is responsible for maintaining an available dispensing stock of some 800 separately compounded preparations. These pharmacists prepare 3,944 gallons of liquid preparations and 619 pounds of ointment per month and supervise their packaging and labeling for immediate issue to the outpatient dispensary. In addition they fill, through the use of two machines, a total of 145,500 capsules a month, representing 21 different medicaments. A helper also assists in this project.

All stock, both from general stores and drug manufacturers outside the hospital, is received and checked item per item by these pharmacists, who also maintain the necessary departmental receiving records. All departmental stock is maintained by these pharmacists with the exception of the sterile solution laboratory.

As an example of the magnitude of stock maintained, the following routine items are procured and stored in approximately the following amounts:

Mineral oil	500 gals.
White vaseline	1,500 lbs.
Aspirin tablets	200,000
Alcohol	650 gals.
Penicillin	15,000 vials
Streptomycin	2,000 vials

This is in addition to the medicine bottles, glass ampules, ointment tubes, labels and other packaging materials which must be kept on hand.

The sterile solution laboratory . . is operated by two pharmacists and two helpers. These pharmacists are responsible for the routine as well as extemporaneous preparation, sterilization, dilution and labeling of some 11 gallons of sterile parenteral and ophthalmic fluids which are packaged in issue units varying from small vials holding about 5 drops, ampules of 1cc size, to flasks of quart capacity. The dilution and labeling of some 12,000 separate vials of penicillin and streptomycin is also accomplished here each month.

In addition to this routine sterile solution preparation, the personnel are required to prepare special sterile ampule medications (which are not readily available from manufacturers) upon periods of notice varying from immediately to 12 hours. Along with the primary assignment of supervisor of this laboratory, a pharmacist is also designated as departmental narcotic custodian, whose duties include issue of all narcotics to the custodians of the two subvaults and the maintenance and inspection of necessary perpetual inventory records as required by law.

One pharmacist handles all special orders other than sterile preparations, requiring compounding. The main line of communication from the issuing centers is via dumb waiter and speaking tube to this pharmacist who is also responsible for proper and rapid flow of information on pending orders between basement and sub-basement pharmacy as well as coordination and rapid dispatch of all specially requisitioned stock by the OPD general dispensing unit, particularly during the early morning hours when emphasis is placed on the rapid and accurate delivery of drug baskets.

The front line units . . of the pharmacy are the OPD and the general dispensing unit. It is through these two sections that all dispensing takes place and all contacts with patients and other departments of the Hospital are made. These are the service centers of the pharmacy.

All inter-department requisitions and inpatient orders throughout the Hospital pass through the hands of the two pharmacists assigned to the general dispensing unit. They are responsible for the filling of all orders or requisitions or for their prompt relay to other sub-departments, such as sterile supply or manufacturing laboratories or to extemporaneous compounding, if such an order requires special processing.

Some 200 inpatient orders and credits and 25 special requisitions are received here and processed daily. This particular section also functions throughout the night for emergency requirements. All special medications not carried in pharmacy stock are ordered from a source outside the Hospital from this schedule. All medications to be credited to inpatients are inspected and processed here. Approximately 90 per cent of all telephone calls received by the department are answered here.

Three pharmacists are engaged in dispensing 300 to 350 prescriptions daily to visiting clinic patients. To achieve greater efficiency, the prescriptions are processed in a sort of production line manner, being first checked for accuracy of dosage, legibility of patient's name and address as compared with patient's clinic card, verification of legal signature and registry number of prescriber in the case of hypnotic and narcotic

drugs, rated as indicated by clinic card, pricing and posting of the cost of the prescription with serial number of a cashier slip. The receiving pharmacist must also know if the medicine ordered is available in stock or if it requires compounding.

From the receiving pharmacist the prescription goes to the second pharmacist who types the label required and thus rechecks patient's name, dosage of medication and directions. Then the third pharmacist obtains the prescription and label which is re-read again in the act of filling the order. The properly labeled and packaged medication is then taken to the dispensing window where the pharmacist calls the patient by name with the aid of the public address system and dispenses the medication along with added verbal instructions if required to clarify directions.

In addition to this routine dispensing the assigned personnel are responsible for maintenance of adequate stock. This is accomplished through bi-weekly requisitions on the manufacturing lab and prepackaging room on the floor below. Along with the maintenance of narcotic sub-vault and necessary records, all alcoholic preparations dispensed are noted in order to obtain tax drawback. All prescription mail orders for routine and research drugs are processed here. An actual physical inventory of all stock is also taken every 30 days by the personnel of this dispensary.

Through the establishment of an active internal personnel training program, which includes periodic job rotation of personnel on all schedules, evening staff seminars for the discussion and study of new drugs, and general over-all Hospital function as it relates to the department at present and in the future, the pharmacy makes its concept of service to the patient through scientific endeavor an ever-growing one.

Hospital formulary . . The 1951 revision of the Formulary of The New York Hospital, under the title of "Formulary and Therapeutic Guide," published by Appleton-Century-Crofts, Inc., is a revised continuation of the first formulary of the Hospital entitled "Pharmacopoeia of The New York Hospital" which was published in 1816. It antedated the first United States Pharmacopoeia which appeared in 1820. The fundamental precept of utility for the physician, medical student and other professional members of the patient care team, which was established 135 years ago by the publication of the first formulary, has been preserved by the formulary committee in this revision.

Central sterile supply

■ THIS DEPARTMENT provides all pavilions, operating rooms, and delivery rooms, through daily delivery and pick-up, with sterile dressings, linen, sterile sets for clinical treatments and sterile needles for hypodermic and intravenous use. The daily delivery schedule includes 70 stations, and distribution of the following supplies:

1,000 packages of sterile dressings
1,200 pairs surgical gloves
30 containers . . sterile vaseline gauze
30 containers . . sterile vaseline packing — various widths
20 containers . . sterile xeroform gauze — various widths
200 drums containing assorted sterile dressings, surgical towels and pads
2,500 sterile pads for obstetrics
20 sterile sets for clinical treatments — bronchogram sets, cut down and tracheotomy sets and tubes and all trays needed for cardiac catheterization.

In addition to the director of central sterile supply, the department includes 1 supervisor, 23 trained technical workers, 1 needle technician, 2 sterilizer operators (1 for day . . 1 for evening) and 3 delivery men.

This department is located on the 10th floor of the Hospital in close proximity to the operating rooms and consists of a sterilization room, needle room, rubber glove testing section and a storage section for all sterile items.

Sterilization . . of all supplies used by the institution, including large quantities for general operating rooms, private operating rooms, gynecological operating rooms, delivery room packs and linen for the pediatric department is carried out by means of four autoclaves, three of which allow for automatic as well as manual operation, and one dry heat sterilizer.

The sterile needle service supplies the Hospital with an average of 21,000 sterile needles per week. Six honing and rinsing machines are used.

Personnel department

■ THE PERSONNEL DEPARTMENT functions as a staff service, offering advice and services to all departments in the Hospital. The functions that are carried on in the department are recruitment, selection, placement, induction, employe benefits and services, salary and wage administration, keeping records, promoting safety, and the handling of employe relations. The responsibility of this department covers 180 different job classifications and approximately 3,000 employes. Recruitment is handled for all positions with the exception of the professional group.

The department is comprised of eight people . . the director of personnel, assistant to the director, employment manager, preliminary interviewer, secretary, record clerk, locker room matron, and messenger.

All requests for new employes clear through the personnel department, and new employes are referred to the department head, who actually makes the final decision of placement.

Each new employe is given a descriptive booklet describing the Hospital, its operations, and opportunities offered to employes. At the same time, the new employe is told of the benefits offered by the Hospital, such as Blue Cross, which every employe may have free of cost, group life insurance, which is available at low cost . . the amount depending on the total earnings of the employe.

Committee on policy . . In order to build firmer relations with employes and thoroughly to acquaint all supervisors with Hospital policies and make improvements, a committee on personnel policy was formed, which is headed by the director of personnel. The committee is composed of representatives of the largest departments of the Hospital. This committee meets regularly for group discussions on employe relations, problems of policy, initiation of new projects, etc. Information thus exchanged leads to unification of personnel practices and policies with consequent increased job satisfaction from the standpoint of both employe and administration. This committee's recommendations are presented to the administration for approval.

Safety . . In addition to other duties, the personnel director is chairman of the safety committee of the Hospital. The safety committee meets once each month and reviews accidents that have occurred and takes steps to prevent their recurrence. The members of the committee represent engineering, building service, laundry and linen service, general stores, nutrition, nursing, and psychiatry. Several safety awards have gone to the Hospital.

Recently, 22 supervisors in various departments of the Hospital participated in a series of discussions relating to the subject of "Dynamics of Supervision and Human Relations." This was given under the auspices of the New York State School of Industrial and Labor Relations of Cornell University. The discussions consisted of eight weekly sessions conducted by Harvey Schoenfeld, assistant director of Montefiore Hospital and a member of the extension staff of the School of Industrial and Labor Relations.

In view of present-day competitive employment practices, the personnel department of a hospital must aim to meet the same benefits and employe needs that industry is meeting and still maintain an enterprise which must constantly meet the patient's needs.

Personnel health service

■ THIS DEPARTMENT is set up principally as a service organization to which any and all employes of the Hospital may go for advice concerning illness as well as for diagnosis and treatment. Over 20,500 visits a year are made to this service by Hospital employes.

In addition to the director of personnel health service, the department includes two part-time doctors, one nurse, one receptionist and a maid.

The Hospital community consists of about 3,000 employes, and in the course of a typical day, some 8 or 10 applicants receive their pre-employment physical examinations and about 40 employe visits are handled. In general, the work of this clinic can be divided into three categories of equal importance: job placement, diagnosis and treatment, and preventive measures.

Pre-employment physical examinations are focused primarily on evaluating the health of the applicant in regard to placing him in a position that is commensurate with his physical capabilities. It is not the policy of this service to turn down an applicant because of some disability, but rather to make every effort to use to the fullest all of his abilities.

Through the personnel health service clinic, all of the facilities of the Hospital are made available to employes requiring medical care.

Aim . . The Hospital works always not only to cure sickness but to accelerate the development of new knowledge and methods of preventing it. The ultimate aim is a positive diagnosis of health and, through methods of hygiene and education, to keep employes healthy rather than allow disease to occur at all. Several practical programs to this end are now under way, such as the tubreculosis case-finding program, regular examination of employes exposed to x-rays, radio-active isotopes or carbon tetrachloride.

The director of personnel health service meets regularly with the health service committee for planning and policy formation. With such guidance and with the benefit of the many facilities of the Hospital, the personnel health service looks forward to continued growth in giving the best possible service to our large community of employes.

Telephone system

■ WITH 54 INCOMING and 12 outgoing trunk lines and a 1,100-line dial system, The New York Hospital switchboard is one of the largest telephone systems of any hospital in the city. Twelve full-time and five part-time operators staff the switchboard on 24-hour duty, seven days a week, also maintaining the paging system. Approximately 70,000 outgoing local message calls are placed per month.

The power house has a separate cordless switchboard on one extension of the Hospital exchange, from which seven calls can be relayed to various departments located in that building. A special intercept board in the social service department enables a staff member to take messages for workers who are out of

their offices when calls come through.

Telecarts . . The New York Hospital was the first voluntary hospital in the city to provide bedside telephone service to its pavilion patients by means of a coin box phone-on-wheels, known as the "telecart." So far, this service is provided only on the tuberculosis ward but it is hoped eventually to install telecarts on other ward and semi-private floors.

In addition to the TRafalgar 9-9000 exchange on which all Hospital, nursing school and medical college calls are received there is an 80-line sub-switchboard with a different number in the nurses' residence.

Telecart . . brings pay telephone to bedside of patients in tuberculosis pavilion of The New York Hospital . . a practical novelty much appreciated by the bed-fast

Nutrition department

■ THE NUTRITION DEPARTMENT, with a staff of 34 dietitians including the director, associate director and six assistant directors, and 309 other employes, prepares and serves about 7,000 meals a day to patients, staff and students at The New York Hospital-Cornell Medical Center. About 55 per cent of all patient meals served require special dietary modifications and about 40 different kinds of special diets are prepared daily.

The department prepares formulae for about 120 infants per day in a special infant formulae laboratory, the daily operation involving about 1,000 bottles. The department also does catering for between 25 and 50 luncheon, tea or dinner meetings each month and for such major occasions as Charter Day, graduation receptions, service anniversary dinners, etc. It bakes a fancy cake for each patient whose birthday occurs while in the Hospital.

Educational activities . . In addition, the department carries on an extensive educational program for patients, nursing and medical students, and dietetic interns, this instruction being carried on by the entire professional staff. Each week about 170 outpatients, through the nutrition clinic, and 30 inpatients, through floor dietitians, receive individual instruction on diet to enable them to carry on their specific dietary modifications at home.

Nutrition . . in The New York Hospital is symbolized by salads (above) and by the weighing of meats (below) in this composite photograph

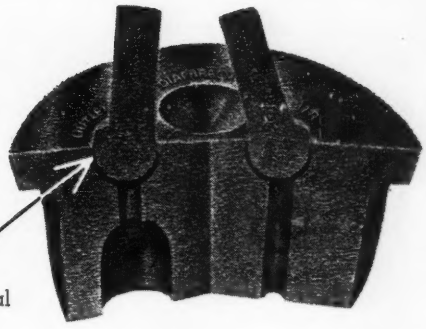
Every student nurse has six weeks of supervised training in the dietary care of patients, including courses in nutrition, cookery and diet therapy, and third and fourth year medical students have classes in which the practical application of various dietary treatments for patients is discussed. They also have supervised experience in nutritional studies in public health and in teaching patients principles of normal nutrition. Each year, the nutrition department accepts 18 graduates of accredited college Home Economics courses for its dietetic internship program which is approved by the American Dietetic Association.

The nutrition department supervises two kitchens.

The main kitchen . . (in the sub-basement), which prepares about 6,550 meals daily for pavilion and semi-private patients and for the four non-profit cafeterias and two soda fountain-lunch counters for personnel of the Center (one lunch counter is for outpatients), contains eight specialized working units.

There is the bake shop where all cakes, pies and other desserts are prepared, as well as all rolls, sweet breads and wholewheat bread; an ice cream room producing an average of 1,500 quarts weekly; a dairy room where the 1,680 quarts of milk and 275 dozen eggs used daily are stored; a salad room, where about 1,850 salads per day are set up; a butcher shop that prepares an average of 9,000 pounds of meat, fish and poultry per week for cooking; a vegetable room where all vegetables are prepared for cooking, and a diet kitchen where all special items, including liquid nourishment and tube feedings, are prepared and distributed in bulk.

There is also a frozen food locker, 30 feet long and 9 feet wide, which can hold about a two-weeks' supply of frozen fruits and vegetables. Food is transported by electrically heated conveyors from the main kitchen to the 24 pavilion and semi-private serving pantries where it is served under the supervision of the 12 therapeutic dietitians.



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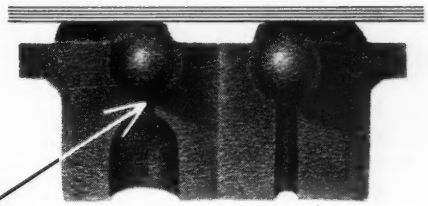

Secondary seal—ball valve under pressure and vacuum.

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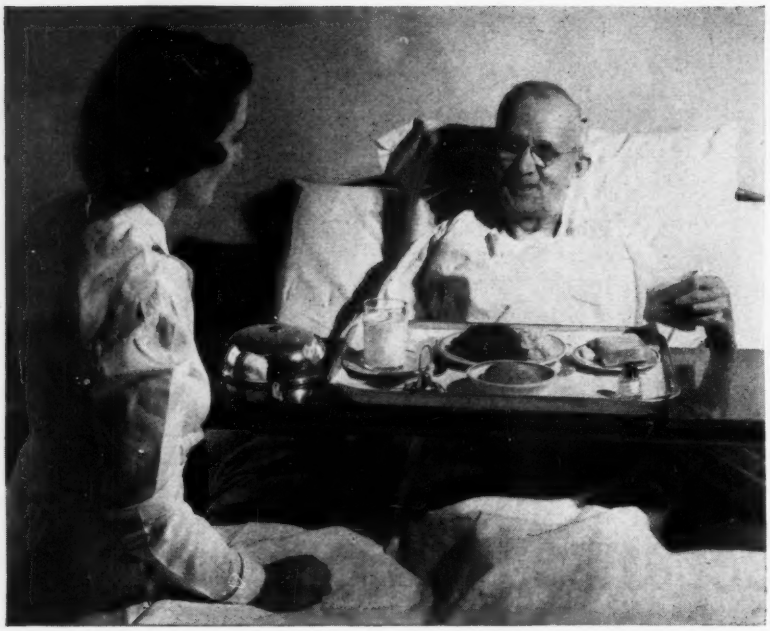

Cordial dietitian-patient relationships . . are encouraged in The New York Hospital

The second kitchen . . is a small complete unit on the 14th floor which prepares about 400 meals daily for patients on private floors plus about 50 luncheons and dinners served in the private dining room on the 14th floor for guests of private patients. All food except desserts is cooked in this kitchen. Trays are served in the kitchen and sent individually on an electric onveyor to each floor.

One dietitian, working with a metabolic research team, plans, weighs, and supervises the serving of research diets to patients in the special metabolism ward.

Payne Whitney Psychiatric Clinic has a small, complete kitchen serving about 108 patients, which is a completely separate operation, although food ordering is done through the nutrition department of the main Hospital.

Two of the employe cafeterias are in the Hospital buildings, one featuring a special dining room for resident staff and attending doctors; the other two are in the nurses' residence and medical college, respectively, the latter being closed during college vacation periods. One of the hospital cafeterias is open until 12:15 A.M. for the convenience of members of the night staff.

Menus . . At The New York Hospital, 12 entirely different menus are offered at every meal, allowing private and semi-private patients and staff several choices for each course. (This does not include the 40 different variations or special diets served daily.) Menus are planned on a weekly basis, 10 days in advance of serving, to allow for checking, cutting stencils and mimeographing of menus, submitting to the patient to obtain his choice, and ordering, purchasing, preparing and serving the food.

Pavilion and semi-private patients' menus are planned by a rotating committee of three therapeutic dietitians, with the head dietitian in charge of this group presiding. A similar rotating committee of cafeteria managers plans employe menus. Private patients' menus are planned by the dietitians on these floors. All menus are submitted to the associate director of the department to be checked for over-all cost, availability and attractiveness.

Dietitians order food by the number of portions of cooked food they expect to serve at each meal; an order clerk in the department converts the portions of cooked food requested into grocery orders. All perishables are purchased daily by the director of nutrition or an assistant, with Friday purchases including weekend requirements.

Prices are obtained daily from at least three wholesalers for all items on the following day's list, and the orders are placed with the lowest bidders meeting specifications. Three copies of all orders are filed, the original showing all quotations and items purchased, filed with accounting to be used as a check against bills submitted, the second copy filed with receiving, which will accept only items listed on the order and in amounts indicated, and the third filed with the food cost accountant for daily reference.

Staples, which include about 400 different items carried in stock in nutrition stores, are requisitioned bi-monthly to the purchasing department which places the orders.

Food storage and control is an important aspect of the nutrition department's "hidden work." Each item in nutrition stores is carried by the food cost accountant on an inventory card showing the date, amount received and price paid. As a basis for daily cost sheets, the food cost accountant uses the order clerk's book with its conversion of cooked food into raw food orders. The accountant costs each raw item, using prices from the purchase orders and issues daily sheets showing the raw food cost for each serving unit and the income from the dining rooms.

A monthly financial statement is used showing the following information for each unit where food is served and the total figure for all units: meal census, total and per capita costs of raw food, labor, supplies, and indirect expenses, total income from all dining rooms and average check and statement of gain or loss for each dining room.

Another important job of record keeping is that relating to the numerous details of personnel administration. There are forms for hiring, requests for raises and transfers, resignation, lay-off or discharge forms, and weekly payroll sheets to be made out for personnel and the payroll office of accounting. All hiring is done within the nutritional department after an initial interview for each employe in the personnel department.

How to avoid false economy when you build your new hospital

To ECONOMIZE, this hospital board has just voted *not* to install Individual Room Temperature Control in the new hospital they are planning to build.

If the board had all the facts, they probably would reconsider their so-called economy move—for later on, it is going to prove expensive. And here's why!

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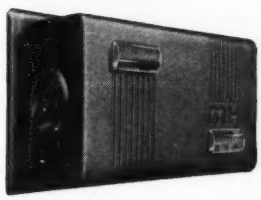
Since that is true, it's wise to install Individual Room Temperature Control *when your hospital is being built,* when it only costs ½ to 1% of the total expenditure. Doing it later, as a modernization project, is sure to cost substantially more money.

For complete facts on Honeywell controls for your hospital, call your local Honeywell office—there are 91 in key cities throughout the nation. Or for literature, write Honeywell, Dept. HM-7-161, 351 E. Ohio St., Chicago 11, Illinois.



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Nursing service and school

■ THE CONCEPT OF GROUP PLANNING to achieve a staff working to full capacity in its combined efforts has been given major consideration by the nursing service.

The New York Hospital Nursing Service, with an employed staff of approximately 600 professional nurses and 500 auxiliary nursing personnel, is at present taking part in several programs designed both to improve coordination of effort between nursing and other Hospital groups and within the various nursing departments.

On the invitation of the medical board, the director of nursing service attends the board's regular monthly meetings and the service is also represented at the meetings of the administrative advisory committee to the director of the Hospital.

A nursing service committee . . composed of the nursing service heads of all clinical departments and the various administrative assistants, has been in operation successfully for many years. This group meets weekly and carries on its work through a number of important subcommittees. Joint planning by supervisors is provided for within each clinical department.

The nursing service operates on a "decentralized" plan. This means that each department is headed by a nursing administrator who assumes the major responsibility for the service, staffing and budget within her department. She has several supervisor-instructors assisting her.

Teams formed . . Both to supplement the nursing staff and to give the professional nurse more time for personal understanding of her patients, the team method of nursing care is utilized. Thus, the Hospital set up, about five years ago, the position of administrative assistant of auxiliary staff to coordinate the service's auxiliary workers. It is filled by a graduate nurse who selects the auxiliary employes; plans their on-the-job training and supervision; plans the necessary steps to acquaint the head nurses with the role of auxiliary workers; and serves as a counselor to the workers themselves.

Since 1940, the auxiliary program has expanded so that now there is a ratio of approximately one auxiliary

worker for every graduate nurse compared to the 1940 ratio of one auxiliary worker for every two nurses.

A further step to free the nurse from non-nursing duties has been taken in the establishing of the position of assistant pavilion manager, who performs such duties as the ordering of supplies, routing patients for x-ray treatment and sending specimens to the laboratory. The plan is in operation in six of the Hospital's wards.

Helping the nurses take over their increasing role as supervisors of auxiliary personnel, are leadership conferences for head nurses and attendance at such courses as "The Dynamics of Human Relations for Hospital Supervisors."

With the reallocation of time-consuming duties formerly carried on by nurses, has come an expansion of programs that directly affect the patient. Among these is a consultation service by which the assistance of the psychiatric nursing staff is available to the nursing service of all departments when patient situations arise that involve complex psychological factors.

Among programs of patient education is a recently established series of three pamphlets that explain to the tuberculosis patient his care, hospitalization and surgical operations. The project resulted from a study in cooperation with the New York Tuberculosis and Health Association.

Continuity between hospital care and care in the home is receiving greater attention. For instance, The New York Hospital Nursing Service has an agreement with the Visiting Nurse Service of New York for referral of patients with diabetes, newborn and maternity patients, premature babies and colostomy patients.

The efficient functioning of this arrangement has been facilitated by full, written understanding in each field as to the nature of care and the division of responsibility. A procedure for referring patients to public health nursing agencies in the locality and outside the state also is operating successfully.

The philosophy of the nursing service . . coincides with the philosophy of the school's educational aims in understanding and helping the total patient . . in relation to his home, his work, his ethnic background and his place in our society. Nowhere is this more obvious in its implications than in the Lying-In Hospital of The New York Hospital, where the nursing service, in its planning, takes into consideration not only the new baby and his mother, but his father and brothers and sisters as well.

The maternity program of the Hospital includes optional courses in preparation for labor (natural childbirth), provision for rooming-in, group discussions with pediatricians on such problems as sibling rivalry, and courses on infant care.

In this department, the patient-teaching program has become so important that it has necessitated a full-time instructor for patients. Student nurses studying in obstetrics and gynecology learn how to conduct conferences with expectant mothers, show them how to practice tension-relaxing exercises and encourage them to ask questions after the baby is born. An in-service program also has been instituted to orient nurses joining the staff to the program.

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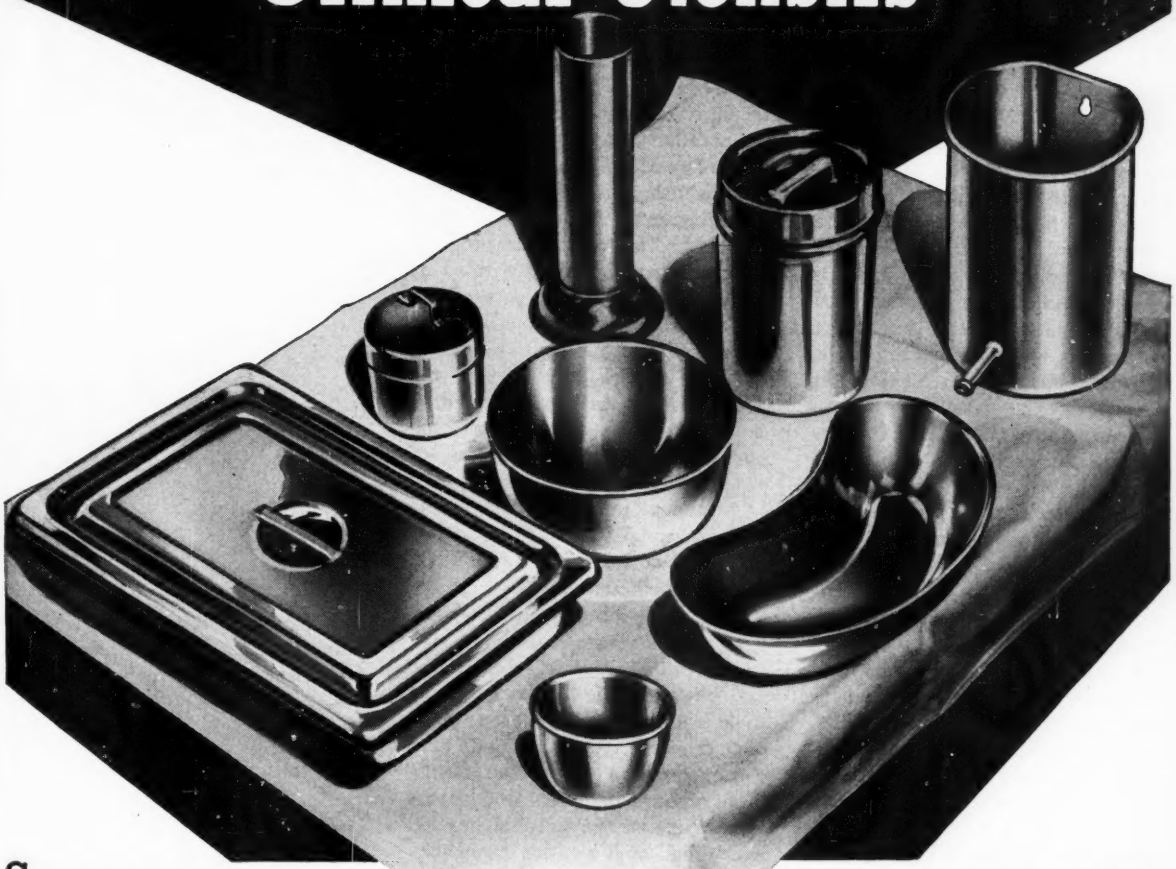

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as the editors see it

They're all good

■ ONE OF THE CHORES one of the commissions in Washington is going to work out is an acceptable definition of a hospital. Just as a starter, it might ponder on the suggestion that a hospital is a place where a person in need of it receives bed care, including nursing. That is certainly the basic requirement, and it serves to underline once more the reason why the nursing problem continues to be one of the most vexed, one of the most difficult, and one of the most controversial if approached in what might perhaps be called the wrong mood. Understandable as this is, it should not be, since every now and then the prevalence of sweetness and light shows that there are no really controlling principles involved on which all cannot agree.

A striking illustration of the most significant aspect of the problem is given by The New York Hospital, one of the country's great hospitals, which is featured in this issue of HOSPITAL MANAGEMENT. The nursing school of The New York Hospital, one of the oldest in the country, celebrated its 75th anniversary recently with suitable ceremonies, including appropriate emphasis on the fact that the school has for some years been one of the limited number requiring two years of college for entrance, and conferring a degree at the completion of the course. Also, the school never has any trouble keeping its classes full, a fact for which the high standing of the hospital and its location in one of the great centers of population are of course responsible. But that is only a part of the hospital's work in the training of nurses.

Another important part of its activities in this connection is its participation in the New York City Cooperative Education Program, in which five of the city's high schools now furnish girls as part-time students in nurse-aid training. Other schools are to join in the program later, incidentally, as it is rated as highly successful as a part of the city's plan to give vocational guidance and education to increasing numbers of girls and boys in the high schools. As now operated in connection with the hospital, the plan involves the organization of girl seniors in work-study teams, each student putting in two weeks in the hospital while her partner is in school at her class-room work, then each taking her turn.

These high-school girls work under professional supervision, receive the prevailing wage for nurse aides, and are assigned to such duties as their training enables them to handle. The interesting thing is that this exposure to training in the simplest of nursing duties and to the atmosphere of the hospital has led nearly half of the entire group taking the training to indicate that they intend to go on with their nurse training to qualify as professional nurses. Several other hospitals besides The New York Hospital are cooperating with the city in this work, and obviously the net result is a valuable addition to the personnel available for bedside nursing of various levels.

The discovery in the now widely-publicized survey by Harper Hospital of Detroit that nurse aides can handle about 30 per cent of patients' treatments, leaving 44 per cent for graduate nurses and 36 per cent for practical nurses, emphasized the fact that professional nurses are still in many cases doing far too many things which less highly trained personnel can handle adequately. The solution to the nursing problem in hospitals all over the country has been found in the training on the job of aides who can and do perform a substantial fraction of the bedside nursing, depending on the experience of the individual and the nature of the patient's illness; and the development of this kind of training has been going on and will continue to go on, it is to be hoped. The trained practical nurse may very well be an increasing factor in the situation, but the aide trained in the hospital, who may or may not take further training beyond that she gains in the actual practice of bedside nursing, undoubtedly far outnumbers the practical nurse in most areas, and will continue to do so.

When a great teaching hospital can find room, in a broad concept of its opportunities for service to the community, both for the student working for a college degree and for the one who is taking the shortest possible cut to actual bedside nursing, it gives an example of what any hospital, almost anywhere, can do in one area or the other to meet its own problems and to afford useful training to the girls of the community. All that is needed is a realization of the opportunity and organization of the necessary supervisory personnel, and both are available in most hospitals. ■

Go away!

■ BY THE TIME this reaches the average reader about three-quarters of the best of the vacation season will still be stretching ahead, into the period beyond Labor Day, and offering to all in the hospital, as elsewhere, the invitation to the benefits of the change of pace and of scenery which are the value of the interlude. It is worth emphasizing that getting away not only from the job, but from the place where the job is, is an important part of the vacation if it is to be of the refreshing quality which it is intended to be. There are a few fortunate people who can find their vacation right

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where they are, but ordinarily this is not the case. The hospital executive should get out of the hospital and out of the city where it is, if this is at all possible, whether to go fishing or to take a motor trip or, as one leading administrator prefers to do, to go hiking. The expression about "getting away from it all" is an accurate index to the way a vacation should be spent, if it is to be truly beneficial as well as enjoyable.

A popular woman novelist who dearly loves nurses . . as who does not? . . has as her favorite theme the lovely nurse who for a perfectly good reason leaves her usual environment, maybe even abandons nursing, only to find herself involved in a situation where she literally has to nurse for dear life. It makes an interesting story, but the busman's holiday, where the busman on vacation rides around in a bus, has never been recommended as the ideal vacation, any more than a letter carrier, weary of walking miles with a load, would be well advised to go along on a hiking trip with the hospital man referred to above. The trick is to accomplish as complete a change as posible, in the daily routine of the individual, so that unaccustomed mental and physical muscles may be given some exercise and those which have been wearied on the job may be rested.

Not only are there now readily accessible far places once beyond the reach of the busy man and woman on a vacation; not only can one at modest cost and with the speed of the age of man's flight reach these places and see them and their people; there are also innumerable spots in this vast country so much worth visiting for pleasure and information that even the inveterate traveler can never exhaust them. From the rockbound coast of Maine, to coin a phrase, to the sunny waters of the Gulf or of the California coast, to say nothing of the lower Atlantic seaboard and the forests and mountains of the Pacific

continued on page 136

hm 25 years ago

■ THE BUILDERS OF HOSPITALS are more conscientious and better-informed nowadays than some of them were a quarter century back, if an article in the July, 1927 issue of **'hm'** is any criterion. Entitled "An Honest Confession of Mistakes Made in a Certain Hospital," by an anonymous author designated only as "the Present Superintendent," the three-page piece is a catalogue of how not to plan a hospital.

The architect was chosen because he was a local man and would take some stock. "He had never had any experience in hospital planning and concerned himself considerably with the front of the building and its ornamentation, that resulted in an additional $10,000 expense, while robbing the interior of the very essentials of solid construction."

An extra person was required on the payroll to perform cleaning of unnecessary molding and other offsets of window and door casings, door panels, etc.

No cut-out valves were installed for sterilizers, gas stoves, etc., making it necessary to shut off the entire building for even a minor repair. Valves were later installed at great expense.

Elevator doors were too small to admit beds.

The laundry chute emptied into a small closet in the hallway between the kitchen and the cafeteria. As a result it was necessary to discontinue its use, and to collect linen in bags on the floors.

An incinerator with only one-can capacity was installed . . and the daily amount of garbage was from twelve to twenty cans!

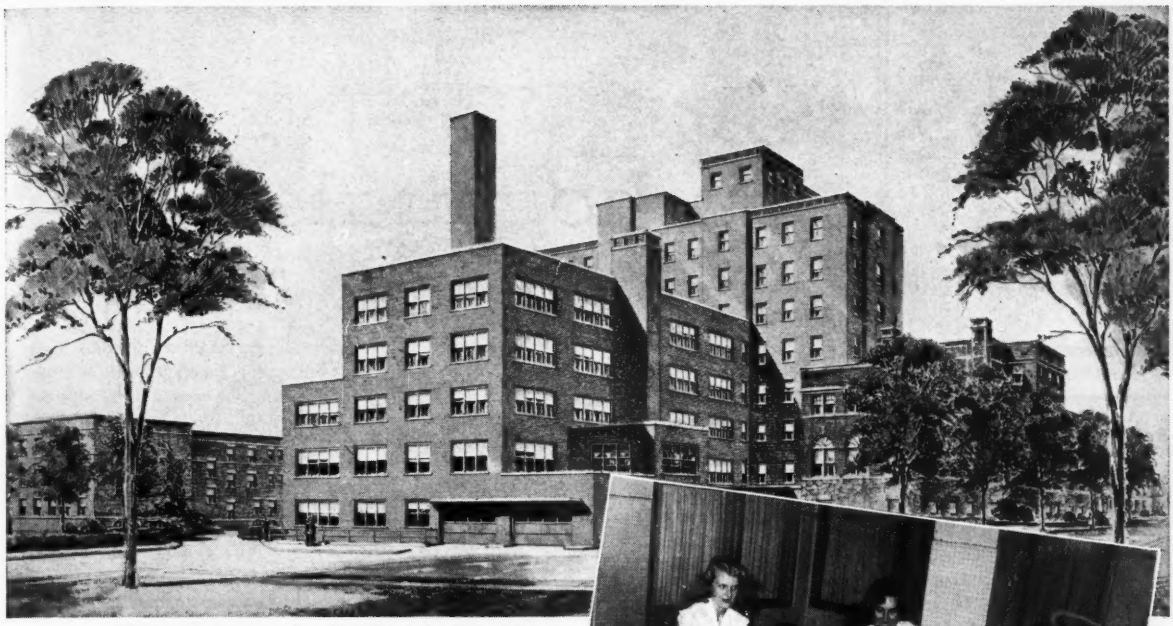
Etc., etc.

■ "HOW A WELL ORGANIZED PHARMACY Lowers Hospital Costs" presents the program of organization worked out by Fannie Seigal, pharmacist of St. Luke's Hospital, St. Paul, Minn. Attention and study given to the proper handling of routine work proved effective in adding to efficiency, avoiding delay in service and equalizing the amount of work done in any one period, thus obviating the "rush" hours when errors are likely to occur.

■ A SPIRITED DEFENSE of the small hospital is embodied in the article by Dr. A. F. Branton (then a representative of the Willmar Hospital, Willmar, Minn.), entitled "85 of 100 Patients Can Be Served by Small Town Hospitals." This might well serve as an apologia for many of present-day institutions built through Hill-Burton funds.

Dr. Branton enumerated the respects in which hospitals of 50 beds or less had progressed: Buildings, equipment, nursing, laboratories, and cited the very real advantages of the so-called "rural" hospital with regard to lower cost per patient day, elimination of difficult trips to metropolitan care, and greater personal attention and interest in the patient because of community cohesiveness.

■ STANDARDIZATION AND REGULATION of a new and fast-growing field of endeavor was advocated by Kano Ikeda, M.D., pathologist of St. Luke's Hospital, St. Paul, Minn. Because there was at the time no general guide for the reliability of laboratory technicians, the American Society of Clinical Pathologists authorized the creation of a board of registry with certain minimum basic requirements in education and training. This was the result of recognizing the important place the laboratory technician had come to occupy in the hospital . . how much more true this is in 1952! ■



Now under construction, New Rochelle Hospital's West Wing, to include a laundry plant where yearly over four million pieces of linen will be washed.

The Therapeutic Pool, where each year hundreds of fracture cases are treated, as well as victims of polyomyelitis.

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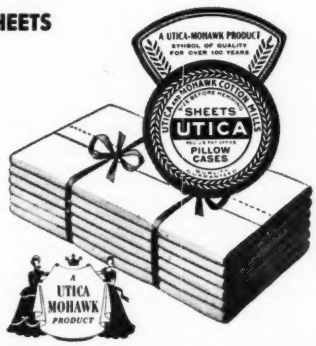

One of the most progressive and constantly expanding hospitals in the country is the New Rochelle Hospital which in New York's Westchester County serves a community of 100,000 people . . . last year treated 10,724 bed patients. Its therapeutic pool is one of the largest and best equipped of its kind along the Atlantic seaboard.

The New Rochelle Hospital is one of many fine hospitals to specify Utica Muslin Sheets. Hospital maintenance costs are so high, that all purchases must satisfy exacting standards of long service. Such hospitals prefer Utica Muslin Sheets because they wear remarkably well and afford patients greater comfort.

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who's who in hospitals

Administrators & assistants

Bailey, Eugene L. . . see **Miller** notice.

Bardsley, Madge, Mrs., RN . . Appointed administrator of Onida Hospital, Onida, S.D., which opens July 1.

Battle, Burton M. . . Appointed administrator, San Jacinto Memorial Hospital, Bayton, Texas, succeeding **Louise Wilkonson,** resigned, who has moved to Greensboro, N.C. Mr. Battle is the former administrator of Lanier Memorial Hospital, Langdale, Ala.

Blythe, Harry A. . . who, already administrator of City Hospital, Winston-Salem, N.C., has been appointed director of both City and Kate Bitting Reynolds Memorial hospitals there, and as such will have over-all charge of the city's medical program from the administrative angle. It is his responsibility to hire a replacement for **E. H. Bradley (g.v.),** who recently resigned as administrator of Kate Bitting Reynolds, and an assistant administrator to replace **W. W. Prior (g.v.),** who has resigned from City Hospital.

Brackens, Letta, RN . . Appointed administrator, Springdale Memorial Hospital, Springdale, Ark., which opens this summer. Previously she was supervisor of Rogers Memorial Hospital, Rogers, Ark.

Bradley, E. H. . . resigned as administrator, Kate Bitting Reynolds Memorial Hospital, Winston-Salem, N.C., where he has been for the past 8 years. Prior to that appointment, he was assistant administrator of Lincoln Hospital, Durham, N.C. Mr. Bradley is a member of the A.C.H.A., the A.H.A. and the A.A.H.A.

Bradley, L. O., MD . . resigned as executive secretary of the Canadian Hospital Council, Toronto, Canada, to accept the position of administrator, General Hospital, Calgary, effective Sept. 1. He has been secretary and editor of the **Canadian Hospital** (official journal of the Council) since August, 1951, prior to which he was director of studies of the Ontario Health Survey Committee. While with the council Dr. Bradley helped organize an extension course in Hospital Organization and Management, and also worked on the compilation of the Canadian Hospital Accounting Manual now being distributed in the Dominion.

Braswell, Taylor O. . . Appointed administrator, Fairfield Memorial Hospital, Fairfield, Ill. Previously he was administrator of Pike County Hospital, Louisiana, Mo.

Canedy, James A. . . Named assistant administrator, Bishop Clarkson Hospital, Omaha, after completing a year's administrative residency there. Mr. Canedy received his MHA from Washington U., St. Louis, last month. He is an Army veteran of WW II, with U.S. and Pacific service over the period 1941-46.

Carson, Leon C. . . Appointed administrative assistant, Robert Packer Hospital, Sayre, Pa., where he served his residency in H.A. Mr. Carson, a graduate of the Course in H.A. at Columbia U., is a personal member of the A.H.A.

Cooper, Wilma M. . . Appointed administrator, Baraga County Memorial Hospital, L'Anse, Mich., after serving for the past 2 years as administrator of Wabash General Hospital, Mt. Carmel, Ill.

Coston, Harold P. . . Appointed assistant administrator, Lutheran Hospital of Maryland, Baltimore. Mr. Coston received his Master's degree in Public Health at Johns Hopkins U. School of Hygiene and Public Health last month. He has just completed a year's administrative residency at the Lutheran Hospital of Maryland, where **Robert S. Hoyt** is administrator. He is a graduate of Wake Forest College ('46).

Emory, Mayo L., MD . . see **Lutz** notice.

Finney, Maude, Mrs. . . see **Miller** notice.

Fuqua, Karey . . see **Wicker** notice.

Gallagher, John Francis . . Appointed superintendent, Meyersdale Community Hospital, Meyersdale, Pa., which opened June 1. Formerly he was superintendent of Garrett County Memorial Hospital, Oakland, Md.

Hatch, Harry . . Named administrator, El Paso General Hospital, El Paso, Texas. He is the former regional director of Blue Cross and Blue Shield at Amarillo.

Haupt, E. O., Mrs. . . see **Mayer** notice.

Higgins, Harry G., Jr. . see **Williams** notice.

Krembs, Gerhard A. . . resigned as administrator, Door County Memorial Hospital, Sturgeon Bay, Wis., and the Algoma Memorial Hospital, Algoma, Wis., to accept the post of administrator of the Ishpeming-Negaunee Hospital, Ishpeming, Wis. His successor is **Herman F. Zimoski, Jr.,** who recently resigned as administrator of Memorial Hospital, Colorado Springs, Colo. Both men are graduates of the Columbia U. Course in H.A.

Leone, Joseph P., MD . . After several months of travel and vacation, returned to Massachusetts to become director of Quincy City Hospital, Quincy, Mass. . . the same post he held from 1935 to 1946, after which he served as director of the Delaware Hospital, Wilmington, Del. and as administrator of the Norwalk Hospital, Norwalk, Conn. Since June 1, 1951 Dr. Leone has been residing at Harwichport, Cape Cod, Mass.

Lutz, Louise, MD . . Appointed director, Sara Mayo Hospital, New Orleans, La., succeeding **Dr. Mayo L. Emory,** who, after being in the post for 3 years, considered his task of reorganizing the hos-

This listing cont'd on page 65

NEW American

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Big Machine Performance...

13 inch brush spread . . . Riding-on-head construction.

Easy Portability...

Reduced weight.

Efficient...

for scrubbing, polishing, steel wooling, disc sanding, buffing, all types of floors.

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It's a beauty any way you look at it! Smart modern styling . . . *new economy and efficiency* . . . easy operation for scrubbing, polishing, steel wooling, disc sanding and buffing all floors . . . wood, tile, asphalt, concrete, rubber, terrazzo or marble. Ideal for jobs requiring easy portability and reduced weight. G.E. heavy-duty motor. Brush speed 172 r.p.m.

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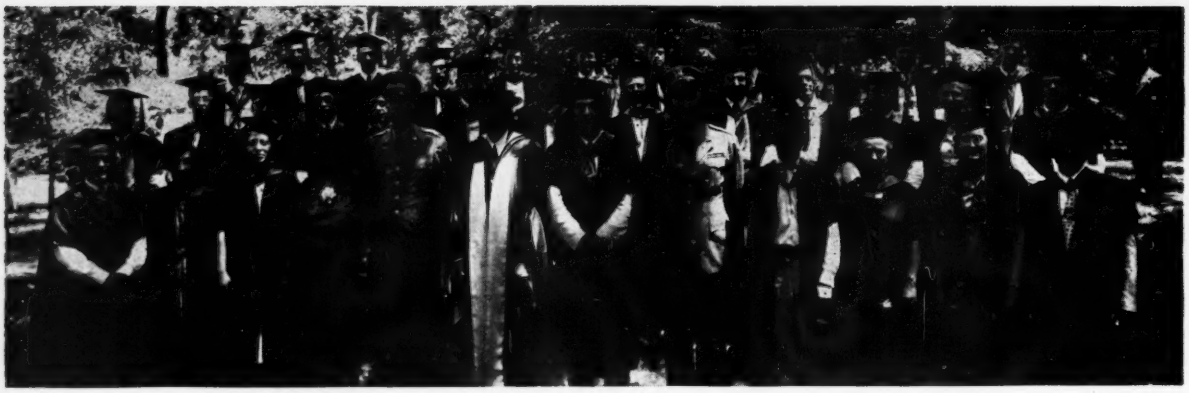
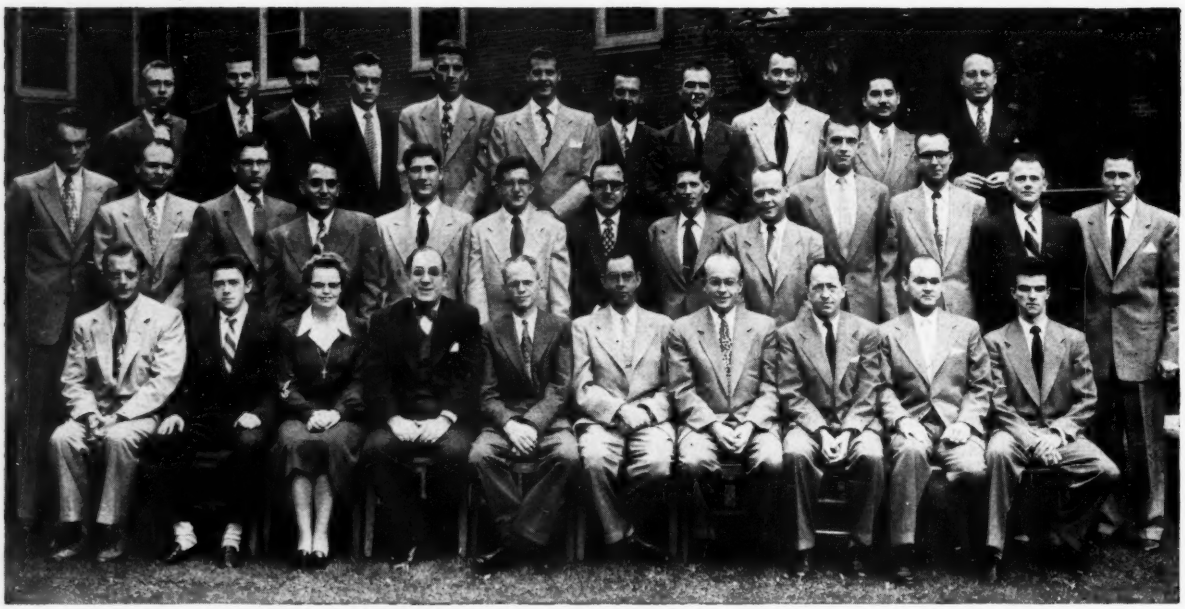


Graduating class in Hospital Administration . . Northwestern University, 1952

Front row, left to right . . Emmett Johnson, Anne Whelan, Edith Beyer, Laura Jackson (associate director), Lt. Col. Sam Edwards, Dr. Malcolm T. MacEachern (director), Harold Peterson, Major Leonard Collier, Ellis Lindhorst, Helen Chase, Lucille Fernleaf, Yeshwant Nilajgi

Second row . . John Eller, Bruce Sledge, Hans Hansen, Wellington Foo, Coleman Foote, James Evans, Proctor Waldo, Sylvester Schroeder, Alfred Riley, James Heidenreich, Steven Pindiak, Janet Burgoon, Dr. Manuel Lander

Back row . . Charles Showalter, Robert Petersen, Roy Colwell, James Ferguson, Orrie Gilbert, Earl Hagberg, Oscar Luther, George Fleigh, Doyle Taylor, Edgar Mansfield, Paul Sodt



Class of 1953, Course in Hospital Administration . . University of Minnesota

(left to right) Top row . . Donald S. Smith II, David L. Odell, Clovis W. Francisconi, M.D., Loren N. Hesla, Gaston Herd, P. David Youngdahl, Gunnar D. Frederiksen, John F. Stockwell, Henry G. Hemmerde, Julio Olavarria, Glenn M. Reno.

Middle row . . Howard R. Jones, Charles A. Okey, R. Bruce Butters, Tomic T. Romson, Ronald M. Cook, William W. Peters, Marshall G. Ause, John P. Davis, Walter V. Coburn, Stanley N. Allen, John Setsma, Jr., Arthur E. Miller, Roger G. Larson.

Bottom row . . George B. Little, Jr., James P. Streitz, Sister Ingeborg E. Blomberg, James A. Hamilton,[1] Gaylord W. Anderson, M.D.,[2] James W. Stephan,[3] Ronald A. Jydstrup,[4] William N. Wallace, Ivan D. Anderson, John O. Yale.

[1]James A. Hamilton: professor and director, Course in Hospital Administration
[2]Gaylord W. Anderson, M. D.: Mayo Professor and director, School of Public Health
[3]James W. Stephan: Assoc. director, Course in Hospital Administration
[4]Ronald A. Jydstrup: instructor, Course in Hospital Administration

Administrators

continued from page 62

pital complete. Dr. Lutz, whose MD degree is from the Long Island College of Medicine, has served as resident at the hospital since March, 1950.

Mayer, James J. . . Named superintendent, Somerset Community Hospital, Somerset, Pa., succeeding **Mrs. E. O. Haupt,** who resigned after 10 years in the post. Mr. Mayer received his MPH degree at the U. of Pittsburgh.

Miller, Harry . . Named administrator, McAllen Municipal Hospital, McAllen, Texas, succeeding **Mrs. Maude Finney,** resigned. He is the former administrator of Gregg Memorial Hospital, Longview, Texas, where he is being replaced by **Eugene L. Bailey,** who previously headed Panola General Hospital, Carthage, Texas.

Moss, James H., Jr . . resigned as administrator, Defiance Municipal Hospital, Defiance, Ohio, to accept appointment as administrator of the Audrain Hospital, Mexico, Mo. He is a MHA from Northwestern U. (class of '50).

Newell, Bernard A., MD . . see **Shaffer** notice.

Nusbaum, Carl . . Appointed assistant director, Michael Reese Hospital, Chicago, after serving as assistant director of Mt. Sinai Hospital in the same city.

Oberg, Albin H. . . Assumed duties as executive director, Lutheran Memorial Hospital, Newark, N.J. After serving his administrative residency at The Malden Hospital, Malden, Mass., Mr. Oberg continued on there as assistant administrator.

Pierce, Harold V., Mr. & Mrs. . . Named administrators, Ogallala Community Hospital, Ogallala, Nebr. Mr. Pierce had been employed for the past 14 years at Methodist Hospital, Omaha.

Prior, Willard W. . . resigned as assistant administrator, City Memorial Hospital, Winston-Salem, N.C., to become purchasing agent at University Hospital, Augusta, Ga., where **R. O. Daughety,** former administrator of City Memorial, is now director. Mr. Prior served as acting administrator of City Memorial between the time Daughety left and **Harry A. Blythe** (q.v.) took over as head.

Rosenberg, Abraham . . Appointed executive director, Hospital for Joint Diseases, NYC, succeeding **Dr. J. J. Golub,** retired. Mr. Rosenberg has been associated with the hospital for 23 years, first as assistant director and for the last 10 as administrator.

Shaffer, Charles L., MD . . resigned as superintendent, Somerset State Hospital, Somerset, Pa., a post held since 1936. His successor is **Dr. Bernard A. Newell,** who has been senior assistant physician at Mayview State Hospital.

Smith, R. Ashton . . see **Waite** notice.

Wachs, Moses . . Appointed superintendent of the new 400-bed Parshelsky Pavilion, Coney Island, N.Y., a branch . . now nearing completion . . of the Brooklyn Home & Hospital for the Aged. Mr. Wachs was formerly assistant executive director of the Home & Hospital of the Daughters of Jacob in the Bronx.

Waite, William H. . . Appointed assistant director, Muhlenberg Hospital, Plainfield, N.J., as successor to **R. Ashton Smith,** who recently resigned to become director of Lawrence General Hospital, Lawrence, Mass. Mr. Waite, a graduate of the Course in H.A. at the U. of Minnesota, served his residency at Syracuse Memorial Hospital, Syracuse, N.Y. For the past year he has been administrative assistant at the Pennsylvania Hospital, Philadelphia.

Wehners, Lester H. . . Appointed assistant administrator, Lutheran Hospital, Omaha, Nebr., a newly created position. He previously had served as credit manager, Methodist Hospital, Omaha.

Wicker, Thomas E. . . Appointed administrator, Southwestern Clinic Hospital, Lawton, Okla., succeeding **Karey Fuqua.** Previously Mr. Wicker was administrator of the North Plains Hospital, Borger, Texas.

Wilkonson, Louise . . see **Battle** notice.

Williams, William R. . . Appointed administrator, Good Samaritan Hospital, San-

University of Chicago . . Class of 1951-52 in Hospital Administration

Left to right: . . James I. Boyce, Victor M. Farrell, Oscar M. Marvin, Charles R. Goulet, Bernard J. Lachner, Clifford Schwarberg, Eugene J. O'Meara, Anthony J. Borowski, Frank B. Hamilton, Robert S. Fohrman, and Charles E. Mathias. (James C. Morrison was absent when the picture was taken.)

ADMINISTRATIVE RESIDENCIES and POSITIONS . . 1952-53

Name	Hospital or Location	Preceptor
Borowski, Anthony J., DPH	Ohio Dept. of Health . . Columbus, Ohio	.....
Boyce, James I.	Ohio State Medical Center . . Ohio State Univ. . . Columbus	.....
Farrell, Victor M.	Dallas City-County Hospital System . . Dallas, Texas	**Albert H. Scheidt, Adm.**
Fohrman, Robert S.	Good Shepherd . . Syracuse U., Syracuse, N. Y.	**Herbert N. Morford, Adm.**
Goulet, Charles S.	Jefferson Hillman . . U. of Ala., Birmingham, Ala.	**Arthur L. Bailey, Adm.**
Hamilton, Frank B.	Veterans Administration . . Houston, Texas	.....
Lachner, Bernard J.	Iowa Methodist . . Des Moines, Iowa	**Donald W. Cordes, Adm.**
Marvin, Oscar M.	N. C. Baptist . . Winston-Salem, N.C.	**Reid T. Holmes, Adm.**
Mathias, Charles E.	Highland-Alameda County Hospital System . . Oakland, Calif.	**G. Otis Whitecotton, Dir.**
Morrison, James C.	University . . U. of Maryland . . Baltimore, Md.	**George H. Buck, Dir.**
O'Meara, Eugene J.	Indiana U. Medical Center . . Indianapolis	**Edward Shea, Adm.**
Schwarberg, Clifford	Ohio State Medical Center . . Ohio State U. . . Columbus	**J. Milo Anderson, Supt.**

Administrative residents* . . of Northwestern University's Program in Hospital Administration, 1952-53

***Front row (left to right):** . . Paul R. Reese; Charles W. Lewis, Jr.; Laura G. Jackson, associate director; Dr. Malcolm T. MacEachern, director; German DeZulueta; Estanislao Montoya.

Second row: . . Joseph M. DeFilippo, David W. Morgan, William B. Barnhart, Robert Carithers, David D. Kramer, Robert J. Lawrence, John C. Ellerbe, Thomas Ray Jones, William B. Calvin, Robert E. Moss, Robert P. Mathieu, Edward F. Hunter.

Back row: . . Philip L. Wisdom, Clarence L. Jackson, Jr., Marcel Letendre, Judson F. Marsters, William K. Hegarty, James H. Henderson, Stanley K. Read, Michael Rodzenko, Richard G. Shedd.

dusky, Ohio, after serving for the past 4 years as assistant administrator of the U. of Illinois Research and Educational Hospitals, Chicago, where his successor is **Harry G. Higgins, Jr.**

Zimoski, H. F., Jr. . . see **Krembs** notice.

V-A & Armed Services

Ale, John H. . . see **Moore** notice.

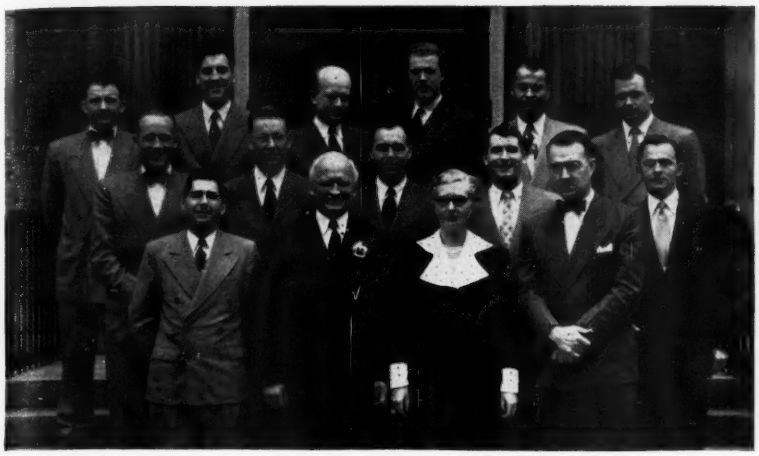
Black, Carl W. . . Named assistant manager of the new 1,000-bed V-A Hospital, East Orange, N.J., effective July 6, after having served as assistant manager of the V-A Hospital, Louisville, Ky. A WW I Army veteran, Mr. Black entered V-A service in 1922.

Cohen, Irvin J., MD . . Appointed manager of the 295-bed V-A tuberculosis hospital scheduled for completion this month in Baltimore, Md. After receiving degrees from the schools of Pharmacy and of Business Administration at the U. of Maryland, he continued to study there and was awarded the MD in 1930. He then served residencies in Philadelphia's Childrens Hospital and NYC's Beth El and Brooklyn Jewish hospitals.

Moore, Bert C. . . Appointed manager of the V-A Center, Dayton, Ohio . . a combination hospital and domiciliary installation . . succeeding **John H. Ale,** who retired. Mr. Moore, who was previously manager of the V-A Center at Wichita, Kansas, has spent most of his 30 years' service with V-A and its predecessor agencies in a managerial capacity.

ADMINISTRATIVE RESIDENCIES . . 1952-53

Resident	Hospital	Preceptor
Allaben, Arthur	Wesley Memorial . . (concurrent) Chicago 11, Ill.	**Ralph M. Hueston, Supt.**
Barnhart, William B.	Harrisburg Polyclinic . . Harrisburg, Pa.	**J. L. MacFarland, Admin.**
Boyd, Eugene	Baptist Memorial . . Memphis 3, Tenn.	**Frank S. Groner, Admin.**
Calvin, William B.	Passavant Memorial . . Chicago 11, Ill.	**John Hatfield, Dir.**
Carithers, Robert	University of North Carolina . . Chapel Hill, N.C.	**Dr. Robert B. Cadmus, Admin.**
DeFilippo, Joseph M.	Fitkin Memorial . . Neptune, N.J.	**David V. Carter, Admin.**
DeZulueta, German	Illinois Masonic (special intern) Chicago, Ill.	**William H. Tenney, Supt.**
Ellerbe, John C.	Orange Memorial . . Orlando, Fla.	**Norman L. Losh, Admin.**
Hegarty, William K.	California . . Los Angeles, Cal.	**Ritz Heerman, Supt.**
Henderson, James H.	Presbyterian . . Denver, Colo.	**Roy R. Anderson, Supt.**
Hunter, Edward F.	Geisinger Memorial . . Danville, Pa.	**Graham F. Stephens, Admin.**
Jackson, Clarence L., Jr.	U. of Colorado Hospitals (Colorado Gen.), Denver 7, Colo.	**Dr. G. A. W. Currie, Dir.**
Jones, Thomas R.	Methodist . . Memphis, Tenn.	**J. M. Crews, Admin.**
Kramer, David D.	Good Samaritan . . Sandusky, O.	**William R. Williams, Admin.**
Lawrence, Robert J.	Herrick Memorial . . Berkeley, Calif.	**Alfred E. Maffly, Admin.**
Letendre, Marcel J.U.	New England Center . . Boston, Mass.	**Richard T. Viguers, Admin.**
Lewis, Charles W., Jr.	Hermann . . Houston, Texas	**Dr. Leigh Crozier, Dir.**
Marsters, Judson F.	Medical Center . . Tyler, Texas	**Lawrence Payne, Admin.**
Mathieu, Robert P.	Worcester City . . Worcester, Mass.	**Theodore A. Austin, Supt.**
Montoya, Estanislao	Louisville General & Sanatorium . . Waverly Hills, Ky.	**S. A. Ruskjer, Admin.**
Morgan, David W.	Lloyd Noland . . Fairfield, Ala.	**Ralph Wadeson, Admin.**
Moss, Robert E.	Memorial of Sandusky County . . Fremont, O.	**Jack A. L. Hahn, Admin.**
Read, Stanley K.	Maine General . . Portland 4, Maine	**Donald M. Rosenberger, Dir.**
Reese, Paul R.	Freedmen's . . Washington 25, D.C.	**Charles E. Burbridge, Supt.**
Rodzenko, Michael	Malden . . Malden, Mass.	**William S. Brines, Admin.**
Shedd, Richard G.	Santa Barbara Cottage . . Santa Barbara, Cal.	**John E. Paplow, Admin.**
Wisdom, Philip L.	Mansfield General . . Mansfield, O.	**W. A. Copeland, Supt.**



Administrative residents . . of the University of Toronto's Program.

First row (left to right): . . D. M. MacIntyre, asst. professor; G. Harvey Agnew, M.D., professor; E. M. Stuart, asst. professor; and L. O. Bradley, M.D., assoc. professor

Second row: . . D. McNabb, E. Roeder, S. Renton, P. Sheridan, O. Clusiau

Third row: . . K. Temple; N. Barr; D. McMillan, K. Palin, J. Thompson, S. Krawchuk

ADMINISTRATIVE RESIDENCIES . . 1952-53

Resident	Hospital	Preceptor
Barr, Norman K., BComm.	Royal Jubilee . . Victoria, B.C.	George Masters, Adm.
Clusiau, Omer H., BA, BSW	Hamilton General . . Hamilton, Ont.	Dr. J. B. Neilson, Adm.
Krawchuk, Stanley D., BComm.	.....	.....
McMillan, J. Douglas, BA, BSW	Regina General . . Regina, Sask.	Dr. H. K. Baird, Adm.
McNabb, Douglas M., BA	Vancouver General . . Vancouver, B.C.	Leon Hickernell, Adm.
Palin, Kerle G., BSc.	Kingston General . . Kingston, Ont.	R. Fraser Armstrong, Adm.
Sheridan, Philip, BScPharm.	Toronto Western . . Toronto, Ont.	A. J. Swanson, Adm.
Roeder, Elmer W., BA	Kitchener-Waterloo, Kitchener, Ont.	Gordon Friesen, Adm.
Renton, J. Sydney, BA	Victoria . . London, Ont.	Dr. Carman Kirk, Adm.
Temple, C. Kenneth, BScPharm.	Toronto East General . . Toronto, Ont.	W. E. Leonard, Adm.
Thompson, John A.S., MD	Royal Alexandria . . Edmonton, Alberta	Dr. D. Easton, Adm.

Villars, Horace S., Col. . . retired from post of commandant, Army and Navy General Hospital, Hot Springs, Ark., on June 30. His successor is **Col. Charles T. Young,** formerly chief medical consultant for the Fourth Army, San Antonio, Texas.

Wilcox, Charles R., Capt., MC, USN . . Named CO of the U.S. Naval Hospital, Camp LeJeune, N.C. He was formerly at St. Albans Naval Hospital, New York.

Miscellaneous Posts

Booth, Audrey, RN . . see **Korngold** notice.

Evans, Armour H. . . Named president-elect of the Kansas Hospital Assn. He is a MHA from Northwestern U. and superintendent of Wesley Hospital, Wichita, Kans.

Fields, Ada A., MRL . . Appointed chief medical record librarian, Robert Packer Hospital, Guthrie Clinic, Sayre, Pa., after resigning as medical record librarian at Dover General Hospital, Dover, N.J. A member of the N.J. Medical Record Librarian Assn. and the A.M.R.L.A., she has been a registered Medical Record Librarian since 1950.

Katzive, J. A., MD . . resigned as director, Mount Zion Hospital, San Francisco (a position held since 1941), to accept an appointment as director of the health services division of the United Auto Workers (CIO). A graduate of Ohio State U., Dr. Katzive served his medical internship and residency at Montefiore Hospital, Pittsburgh, where he became medical supervisor of the outpatient department. From 1934 to 1941 he acted as assistant director, Mount Sinai Hospital, NYC.

Korngold, Janet F., Mrs., RN . . Appointed director of nursing, Children's Memorial Hospital, Omaha, succeeding **Audrey Booth, RN,** resigned. Mrs. Korngold comes to her new post from State Hospital, Yankton, S.D. A graduate of Presbyterian Hospital School of Nursing, Chicago, she holds a Master's degree from Northwestern U., Evanston, Ill.

Mistrik, Leon . . Appointed business manager of Graduate Hospital, Philadelphia.

Plumhof, Lucille, Mrs. . . see following item.

Rieke, Shirley, Mrs. . . Named editor, **The Nebraska Dietitian,** succeeding **Mrs. Lucille Plumhof,** who will join her husband in Japan. Mrs. Rieke is dietitian at St. Joseph's Hospital, Omaha.

Weynand, Robert S. . . Appointed assistant purchasing agent, Watts Hospital, Durham, N.C., after serving with the Institute for Research in Social Science at the U. of North Carolina, Chapel Hill.

Board presidents

Bond, Clint . . Elected president of the board, Baton Rouge General Hospital, Baton Rouge, La., succeeding **Warren O. Watson,** who served since 1949. Mr. Bond is general manager at the Ethyl Corp.

Gordon, G. Blair . . Named president, Royal Victoria Hospital, Montreal, Canada, succeeding **Bertie C. Gardner,** chancellor of McGill U. and president of the Bank of Montreal. Mr. Gordon, who is president of the Dominion Textile Co., Ltd., has been an active member of the board of governors since 1946.

Shelton, William . . Elected head of the board of trustees, College Hill Hospital, Dayton, Ohio. He was recently named president of the Miami Valley Pharmaceutical Assn.

Deaths

Bates, Maxwell B., Mrs., 50 . . Former superintendent of nurses at the Mayo Clinic, Rochester, Minn. She also had been superintendent of nurses at White Cross Hospital, Columbus, Ohio. In Calgary, Canada.

Phillips, Mollie Craig, Mrs., 77 . . Former head nurse at Baroness Erlanger Hospital, Chattanooga, Tenn.

Sister Mary Turibia, O.S.F. . . Administrator, St. Mary's Hospital, Philadelphia.

Civil defense

■ DURING 1951 GREAT PROGRESS was made in planning, organizing and training for civil defense in close coordination with the Medical College, the Rockefeller Institute for Medical Research and Memorial Cancer Center. Detailed plans for providing shelter for patients, employes and staff in the event of enemy attack were tested and found satisfactory in a city-wide air raid drill conducted by the New York City Office of Civil Defense.

The New York Hospital-Cornell Medical Center has been designated a surgical hospital in the over-all disaster plan of the Medical Emergency Division of the New York City Office of Civil Defense. Plans for definitive care for some 3,000 or more seriously injured disaster victims have been made.

One thousand canvas cots were received from the Medical Emergency Division for use in expanding the Center's bed capacity in a disaster emergency. A successful demonstration of the use of these cots in expanding the capacity of one of the Baker Pavilion floors from 23 beds to 123 beds was attended by observers from the Center and other institutions.

Registration of staff, employes and volunteers as official civil defense workers has been very successful. Thirteen civil defense training films have been shown to an aggregate audience of 2,317 employes and staff members. One hundred fifty-one employes completed the standard American Red Cross First Aid Course. Over 80 per cent of the nursing staff received special training for atomic disaster.

Educational programs

■ IN ADDITION to participating in the education of medical students through its affiliation with Cornell University Medical College, graduate physicians and medical specialists through its intern and resident training programs, and student nurses through the Cornell University-New York Hospital School of Nursing, the Hospital furnished formal training to students in many fields allied to medicine.

The average number of students who receive training in each of these allied fields during a given year is indicated below. The length of time spent in training at The New York Hospital by individual students varies considerably depending on the field involved and the requirements of the appropriate curriculum.

HOSPITAL AND MEDICAL ADMINISTRATORS 2
(In association with the Institute of Administrative Medicine, Columbia University.)

HOSPITAL DIETITIANS 16
(Dietetic internships provided by The New York Hospital Department of Nutrition and approved by the American Dietetic Association.)

NURSE ANESTHETISTS 6
(The New York Hospital postgraduate coure in Anesthesia for registered nurses.)

OCCUPATIONAL THERAPISTS 33
(In affiliation with Columbia University, New York University, Richmond Professional Institute of the College of William and Mary, Boston School of Occupational Therapy, College of Puget Sound, Mills College, and University of Pennsylvania.)

PHYSICAL THERAPY TECHNICIANS 78
(In affiliation with Columbia University, New York University and Ithaca College.)

SOCIAL WORKERS 11
(In affiliation with the New York School of Social Work of Columbia University.)

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(In association with New York State Institute of Applied Arts and Sciences.)

School of nursing

■ SEVENTY-FIVE YEARS of nursing education were celebrated this spring by the Cornell University-New York Hospital School of Nursing, which began in 1877 as the New York Hospital Training School for Nurses, one of the first schools of nursing in the United States. It counts among its alumnae such names as Lillian Wald, Julia Stimson and Annie Goodrich. Of equal importance was the simultaneous celebration of the 10th anniversary of the school's becoming a school in Cornell University.

Since 1946, the year that two years of college preparation were first required of *all* entering students, notable developments have taken place in many directions.

In 1947 the school became a member of the Association of Collegiate Schools of Nursing. In 1949, it received joint accreditation by the national organization for Public Health Nursing and the National League of Nursing Education, its graduates thus being designated as prepared for first-level positions in public health nursing as well as in hospital nursing. To this end experimentation in curriculum began as early as 1932 following a study conducted by the National Organization for Public Health Nursing at the request of a committee on nursing organization appointed by the Governors before the new Medical Center was opened. Curriculum changes during the last few years have been primarily related to adjusting the curriculum to the needs of students, all of whom had completed two years of college work before entering. A complete reorganization of the first year will go into effect this fall to parallel the many changes taking place in medical care.

In the last few years, faculty publications have appeared in numerous fields, especially geriatrics, surgical nursing, nutrition, obstetrics and venereal disease, and faculty members have presented papers at nursing meetings and institutes, notably in obstetrics and nursing service administration.

Within the hospital, faculty members have participated in studies in nursing care and nursing service administration. These include nursing of the tuberculosis patient, the patient with a colostomy, the work of the nurse on night duty, and meeting the psychological needs of sick people. The last two of these studies have received the help, through the Russell Sage Foundation, of Professor Leo Simmons, who spent two years on the school of nursing faculty as professor of anthropology in nursing.

The school does not offer academic programs for graduate nurses, but much attention has been paid to discovering and encouraging the development of young graduates and potential faculty members, with the school faculty accepting this as one of their major responsibilities.

In July of this year, the position of dean of the school and director of the nursing service of the Hospital became two full-time positions to bring stronger leadership to both the school and the nursing service.

Recognizing the importance of an endowment for the school, the board of governors of The Society of the New York Hospital in July 1951, transferred to the school a gift of $1,000, thus establishing the endowment fund of the school of nursing. Although it is still in its first year and no campaign has been conducted or is anticipated at this time, the fund was increased by $70,000, a gift from the Hiram Edward Manville Foundation and by other gifts, and now totals $75,000.

In 1947 a group of some 100 women from the New York area organized the committee for scholarships of the Cornell University-New York Hospital school of nursing. Aiming to give financial aid to qualified young women wishing to prepare themselves for careers in nursing, the group has so far raised $14,400 for scholarship funds for the school. To date 50 students have benefited by their scholarship grants.

These advances have coincided with another advance . . that of enrollment. With the largest entering class in its history, 87 students, last fall, the student body now totals 200, all having completed two years of college before admission and all enrolled in the degree program.

Like the undergraduates of any college, they conduct their own student government, participate in a wide range of school activities and have a counselor whose time is devoted entirely to their activities and problems.

The program is planned so that by the time the students are seniors, they are ready to accept almost complete responsibility for analyzing and planning to meet the nursing needs of their patients. Also, from the very beginning, the student learns the role of auxiliary personnel and begins to assume responsibility for working with them. She gradually takes responsibility for them, as team leader, in her third year.

The program takes the students into the community. All students receive eight weeks field experience with the Visiting Nurse Service of New York, learning bedside care in the home and health supervision of the entire family. A few seniors, each year, have the opportunity of an additional public health experience, usually rural, with the New York State Department of Health.

For more effective planning between the school and alumnae, the Alumnae Association has this year appointed a full-time executive secretary. To commemorate the 75th anniversary of the school, a short history of the school has been published and was presented to all alumnae on June 12.

Public relations department

■ PRESENTING THE STORY of The New York Hospital . . its services, medical accomplishments and its needs to the community . . is the work of the public relations department, which, with its staff of nine, is probably one of the largest departments of its kind in a voluntary hospital.

Behind its work with newspapers, magazines, radio and television, and its own informational publications for patients and friends of the Hospital, lies the essential purpose of the department's existence: raising funds to meet the ever increasing demands for care of the needy sick.

In addition to bringing the Hospital's story before the community through these customary public relations channels, the department also assists in the preparation and checking of material for publication by doctors, nurses, and other staff members; supplies material and pictures to outside agencies developing articles on phases of the Hospital's work; conducts a once-a-week tour of the Hospital for interested persons and arranges special tours for visiting nurses, doctors, and dignitaries. It issues daily condition bulletins to the press on patients who are in the public eye, and may arrange press conferences for them. The department develops and sends out its own fund-raising appeal literature and records all gifts made to the Hospital.

There are other "publics" in The New York Hospital family. To communicate with each of them, the public relations department produces special publications: "The Pulse" for employes, "The Report of Service," a pictorial supplement to the Annual Report; "The Record," a story and picture report of the Hospital's activities and "Milestones" a historical folder for friends outside the Hospital, and informational handbooks concerning private, semi-private and pavilion services for entering patients. Other publications of the department include the annual Nursing School Bulletin, a Mother's Book, Student Nurse Handbook, pamphlets on the Children's Blood Transfusion Clinic, the Audiology Clinic, and the like.

This department cooperates in the organization and planning of special activities such as the annual Charter Day Celebration and the anniversary dinner for long service employes, as well as other special events.

The Department of Nursing Service is under the editorial direction of Dina Bremness, superintendent, Glenwood Community Hospital, Glenwood, Minn.

nursing service

Does practical nurse education offer challenge to hospitals?

by **Florence Slown Hyde** Hospital public relations counsel

■ DESPITE THE SERIOUS SHORTAGE of registered professional nurses and the scant hope that the supply can be increased to any great extent, hospital administration by and large has thus far failed to give serious consideration to the challenge which practical nurse education offers as a means of providing trained personnel capable of doing the major portion of the bedside nursing under proper supervision in the hospital.

The above assertion should not be construed to mean that hospital administrators generally are averse to employing practical nurse graduates who may be available for staff positions. In fact, the demand for this type of personnel in hospitals is so great that most schools of practical nursing report only a very small percentage of graduates are engaged in private nursing in homes, a field regarded as in great need of persons capable and willing to perform some household tasks as well as care for the sick. It is also of interest to note that, aside from graduates of schools maintained by institutions for the care of the chronically or mentally ill, general hospitals are the preferred choice of practical nurse graduates as places of employment.

However, a willingness to employ trained practical nurses falls considerably short of meeting the challenge of practical nurse education as an alternative in the present nursing crisis. A passive attitude will not provide nursing personnel to staff that new unit now in process of construction or the floor that has been closed because there weren't enough nurses available, or to give patients the care they don't get during the night shift because some registered nurses will not accept night duty.

Need stability . . Nurse aides, trained on-the-job in many hospitals, are helping to fill some of the gaps created by the shortage of professional nurses and could do even more to conserve the available nursepower still being squandered on housekeeping and errand girl's tasks to an almost unbelievable extent in far too many hospitals, as revealed in a recent survey. However, the terrific turnover in this type of employe, due in part to the lack of opportunity for advancement, combined with the limited training that is given, point up the need for a more stable and better trained person as an addition to the nursing team.

Practical nurses who are graduates of standard training courses have demonstrated their ability to perform acceptably a wide range of tasks required in the bedside care of patients, as well as the ability to advance to posts of responsibility through experience and further on-the-job training for specific types of service. They are also demonstrating greater stability than either nurse aides or graduate professional nurses if studies made by several schools are a criterion.

Despite these favorable implications and the increasing demand for practical nurses on hospital staffs, administrators generally remain on the sidelines instead of getting in there and pitching to help plan and develop practical nurse education programs to meet hospital and community needs.

Recent reports indicate that less than 300 among 6,800 hospitals in the entire country are participating in practical nurse training programs as carried on by approximately 179 state approved schools in states having licensure laws and 15 schools in other states accredited by the National Association for Practical Nurse Education, with a few more in process of being established or expected to receive approval in the near future.

Two of the 36 states having laws providing for licensure of practical nurses, vocational nurses or nursing attendants have no schools, five states have only one school each, and eight states have only two schools each.

Recruitment lags . . Although some schools have demonstrated that it is possible to secure full or nearly

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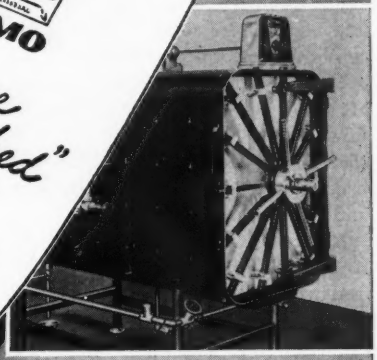

APRIL
MEMO
Announce "All-Welded" Monel Construction for American Sterilizers
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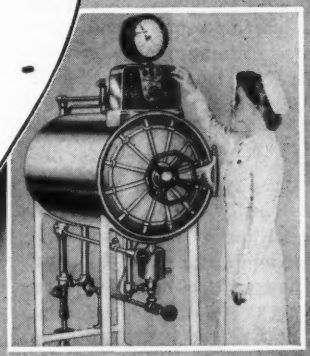
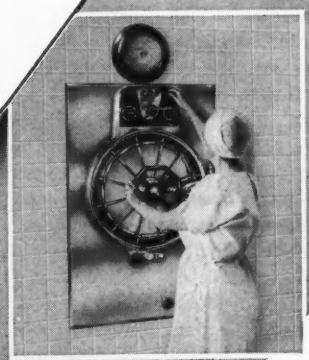


MEMO
Announce "Cyclomatic-Control" for American Sterilizers
1950



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full enrollment through an adequate public relations program, recruitment lags in most practical nurse schools for want of such a program and because of other removable obstacles, which will be pointed out later in this article.

Late in 1951, Miss Hilda M. Torrop, R.N., executive director of the National Association for Practical Nurse Education, reported that the 180 schools, then accredited, had a total enrollment of only 7,000 students. Hence, it may be assumed that total enrollment in 194 schools presently accredited is slightly in excess of 7,000. On the other hand, Miss Torrop and other leaders in this field have stated that at least 15,000 practical nurses should be trained annually to meet present and future demands.

According to Miss Margaret F. Knapp,, R.N., specialist in practical nursing, U. S. Office of Education, there are approximately 12,000 public secondary schools which offer vocational training courses of various kinds under the Federal aid program. Of these, approximately 150 are now offering some type of practical nurse training, which has been approved by the respective State Boards for Vocational Education in 38 states. However, a recent survey by the writer indicates that only 110 of these programs have been approved also by the nursing education authorities in states having licensure, while only eight such schools located in other states have been accredited by the National Association for Practical Nurse Education.

Of the 77 other state or NAPNE approved schools of practical nursing, 62 are maintained entirely by hospitals, five are maintained by colleges or universities, and nine are sponsored by various community agencies.

Each of the 132 programs sponsored by public vocational education, colleges or community agencies has one or more hospital affiliations for clinical experience and instruction, to which the practical nurse student is assigned for two-thirds of the time which is allotted to the training course in most programs. Since regulations in most states stipulate only 4 to 6 hours of a 40- to 44-hour week (48 hours in a few states) must be devoted to planned classwork, the affiliated hospitals receive student service which justifies employment of an instructor-supervisor and student compensation in the form of maintenance or stipends or both. Thus the hospital is able to participate in an educational program which provides trained personnel without making the heavy financial outlay required to maintain a professional nursing school.

On the other hand, those hospitals which provide the entire course must meet the instructional costs for the preclinical portion during which the student renders little service, as is the case with the professional nursing student. The hospital must also provide classroom and other teaching facilities for the preclinical period, although a hospital that formerly operated a three-year school usually has these facilities at hand.

Approved schools . . Despite the extra financial outlay, 62 hospitals are now maintaining approved practical nursing schools on their own. Tuition helps meet the instructional costs which are less in a hospital school than for a school sponsored by public vocational education. In some of the smaller hospital schools described in previous articles of this series, only one extra nurse instructor was needed in addition to personnel already available on the hospital staff, while the director of nursing service doubled as director of the school, just as is done in most hospitals maintaining professional nursing schools. Some hospital schools provide maintenance throughout the course, supplementing this with stipends during the clinical period. Others provide stipends or maintenance during the clinical period only.

The extent to which a hospital can afford to subsidize practical nurse training is a subject that should receive careful consideration. It involves many factors, not the least of which is the opportunity to screen applicants more carefully than may be possible in a program sponsored by public education.

Inadequate screening . . In any case, inadequate screening is one of the criticisms that has been voiced by some hospital administrators who have cooperated in programs conducted by public education. It would seem that if the hospital is to help turn out the product and make use of it eventually, it should have a voice in determining policies and program, including the selection of students. In this as in some other areas of public participation in matters affecting hospitals, the voice of the latter should not be shouted down by a preponderance of opinion from people who have little knowledge of hospital needs and problems.

While stating that there are 12,000 public secondary schools which now receive Federal and state aid for some types of vocational training, Miss Knapp of the Office of Education points out that practical nurse training should be included in these programs only after surveys have determined the need for trained practical nurses in a given area and the availability of student prospects.

Miss Knapp also calls attention to the limited supply of instructors, a situation that is well known to administrators of hospitals that have professional nursing schools. Practical nurse leaders want directors and instructors who have degrees but this is not an ironclad requirement in all of the state regulations, indicating a realization that those having degrees may not be available and that it is possible for experience and other qualifications to offset the lack of a degree.

In practical nurse schools set up as part of public education, the director or coordinator, as she is frequently called, and professional nurse instructors must meet the general educational requirements stipulated for other faculty members in addition to having the necessary preparation in the field of nursing education.

Schools closed . . Statistics of the American Nurses' Association show that there were 225 fewer state-approved professional nursing schools on January 1, 1951 than in 1938 and 125 fewer than in 1945. It is known that increased costs and inability to obtain faculty personnel with qualifications demanded by state regulations have resulted in the closing of a considerable number of schools

since January 1, 1951 although authentic statistics are not presently available.

Now, the American Hospital Association states that approximately 25 per cent of the remaining schools have failed to qualify for temporary accreditation by the National Nursing Accrediting Service and has asked that this list be not publicized because of its possible effect on the recruitment efforts of those schools. The extent to which the accrediting program may eventually result in the closing of schools is a matter for conjecture but it seems inevitable that professional school mortality will be accelerated by this and other factors.

To every hospital which has closed a school but still has its facilities intact and to every hospital that now is facing the issue of closing its school, practical nurse education offers a challenge that merits serious consideration. The few hospitals which have changed from professional to practical nurse training are well satisfied with the results, as reported in preceding articles in this series. Some, like Mercy Hospital in Marshalltown, Ia., are maintaining a school of practical nursing entirely on their own. Others, like Theda Clark Hospital in Neenah, Wis., are providing the facilities for a program conducted in cooperation with vocational education. Other hospitals in other states can follow these and other examples, instead of junking facilities and the contacts which have been made through the years. The results will justify the effort required.

Practical nurse education offers a challenge to many other hospitals that have never participated in the training of nurses as well as to many of those that now have schools of professional nursing which they have no intention of closing.

Salvaging students . . How many applicants did your school turn down recently because they could not meet the academic requirements? How many students have withdrawn from your school in the last two years only because of failure in classwork? How many in each category really wanted to be nurses and had the other qualifica-

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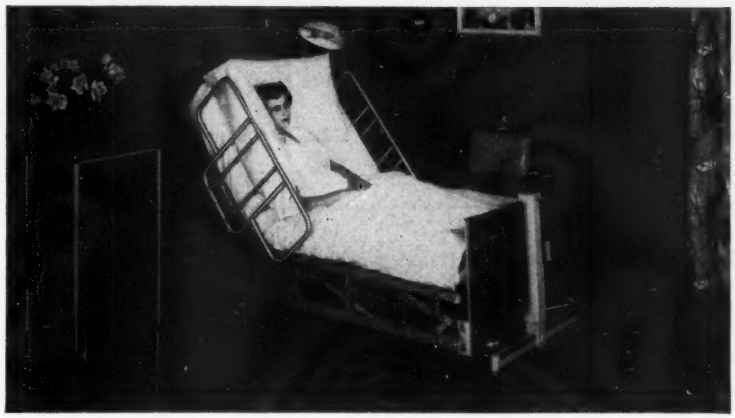

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tions needed for service in this field? Do you know that studies made by the National League of Nursing Education in 1947 showed that failure in classwork accounted for 36.1 per cent of the student withdrawals during the first six months, 27.4 per cent of the withdrawals in the second six months, 18.4 per cent in the second year, and 10.8 per cent during the third year? (See page 46, *1951 Nursing Facts*, published by the American Nurses' Association.)

Based on the number that withdrew during the three-year period from the schools reporting, the number of students withdrawing because of failure in classwork totaled nearly 2,400. How many of these could have been salvaged for nursing had they been given an opportunity to take a course in practical nursing and given proper encouragement to do so? We have no way of determining this but we can take steps to salvage such young women in the future.

Although hospitals with professional nursing schools have not been encouraged by nursing education leaders to conduct a practical nurse training program, a number of hospitals and at least five colleges are successfully conducting both types of programs. Among the hospitals doing this are Charity Hospital, New Orleans, La.; St. Mary's Hospital, Rochester, Minn.; South Baltimore Hospital, Baltimore, Md.; Beverly Hospital, Beverly, Mass.; Tayloe Hospital, Washington, N. C. and several in Idaho. Universities and colleges conducting both types of programs include: Baylor University, Dallas, Tex.; University of Houston, Houston, Tex.; University of Kansas, Kansas City, Kan.; Madison College, Madison College, Tenn.; and University of Minnesota, Minneapolis.

Comment . . Commenting on the feasibility of conducting the two programs, *Practical Nurses in Nursing Services*, issued by the Joint Committee on Practical Nurses and Auxiliary Workers in Nursing Services, states:

"If a school for professional nurses and a school for practical nurses are operated under the same auspices, substantial control of the educational aspects of the curriculum and practice is imperative. When so operated, separate faculties (with the possible exception of clinical instructors and supervisors) should be provided for each school and appropriate classroom facilities and well-supervised clinical experiences should be available for each group. It is advisable that the names of the two schools be entirely different to avoid confusion in the minds of the public."

There seems to be some disagreement with the above pronouncement in actual practice in the matter of separate faculties and special classroom facilities although it is conceded that those who instruct practical nurses must have a clear understanding of the limited scope and content of teaching to be included in the practical nurse curriculum.

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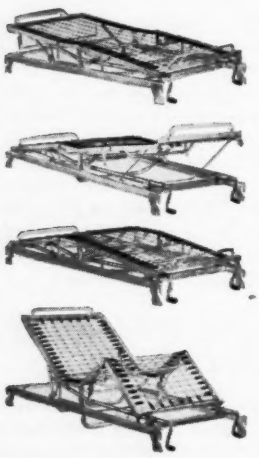

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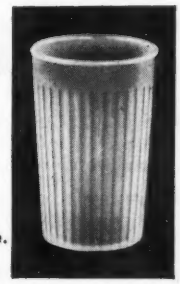

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Although some state approving authorities will not permit a hospital with a professional school to provide clinical training to practical nurse students, some of the best programs being conducted in other states are not hampered by such restrictions. These include the Milwaukee Institute of Technology program with which five hospitals with professional nursing schools are affiliated to provide clinical experience and instruction, the Connecticut program in which all of the hospitals that provide clinical training to attendant nurses have professional nursing schools, and the Rochester School of Practical Nursing, Rochester, N. Y., which has affiliations with two hospitals that have professional schools.

Many other successful affiliations of this type belie the necessity for arbitrary regulations that forbid participation by the same hospital in both professional and practical nurse education.

High school training . . Another possibility in the field of practical nurse education which challenges the interest of hospitals is the setting up of more approved training programs as part of the regular high school curriculum in the senior year. Two such programs, now being conducted in Virginia, were described in some detail in the May issue of this magazine. Nursing and vocational education leaders have not encouraged this type of program because they feel that senior high school students are too immature, despite the fact that 20 states license practical nurses at 18 years and one state (California) has a minimum licensing age of 17 for vocational nurses, the title used in that state. Moreover, graduates of such programs have the advantage of a complete high school education, which is more than is specified in most state regulations for those admitted to practical nurse schools on the adult education level.

Although a few schools of practical nursing have affiliations which provide some experience in the care of mental patients as part of the basic course, it would appear more desirable to offer postgraduate affiliations in psychiatric nursing as has been recommend for practical nurse schools by the State Committee on Nursing Education in Rhode Island. In fact, an increasing number of schools and affiliated hospitals are making postgraduate training in various specialized fields available following completion of the basic course.

Baylor University offers the most comprehensive program for specialized study through its six-month technician nurse internship plan which was described in the June issue of this magazine. The values to be derived from this plan challenged consideration by all who are interested in providing trained nursing personnel to augment the

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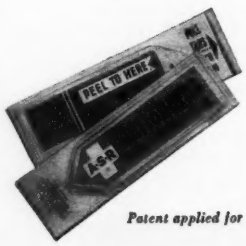

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diminishing supply of professional nurses for service in operating and delivery rooms and other areas within the hospital as well as in other fields outside the hospital.

With the shortened hospital stay and the trend toward providing home care under hospital supervision, the plan of some practical nursing schools for a supervised home nursing period following completion of the basic course seems destined to meet a real need, particularly in the care of mothers and newborn and the chronically ill.

Bedside nursing . . Along with the various developments looking toward the widening of the training and job opportunities of practical nurses, it is well for hospitals and practical nurse educators not to lose sight of the great need for competent personnel to do bedside nursing, lest we educate this group away from the bedside as seems to have been the case in the education of professional nurses.

In its monograph on "Minima Suggested Training Programs for Vocational Nurses in Texas," the Texas Board of Vocational Nurse Examiners strikes a keynote which might well serve as a guide for basic courses throughout the country. "The primary objective," asserts the Texas Board, "is to produce competent bedside nurses. Therefore, the course is centered around the practice of bedside nursing instead of being divided into many isolated units. Since procedures in bedside nursing cannot be taught without some knowledge, on the part of the students, of anatomy, physiology, bacteriology, nutrition, pharmacology, etc., all of the allied courses should be integrated into such procedures. It is the purpose of this committee to develop a pattern that will insure the teaching of the fundamental principles of good bedside nursing care in the home and in the hospital. It is not intended to suggest a curriculum that will prepare specialists."

This does not mean that the practical nurse should be denied the opportunity for advancement through specialized training but it does mean that such training shall be elective following completion of the basic course instead of requiring all stu-

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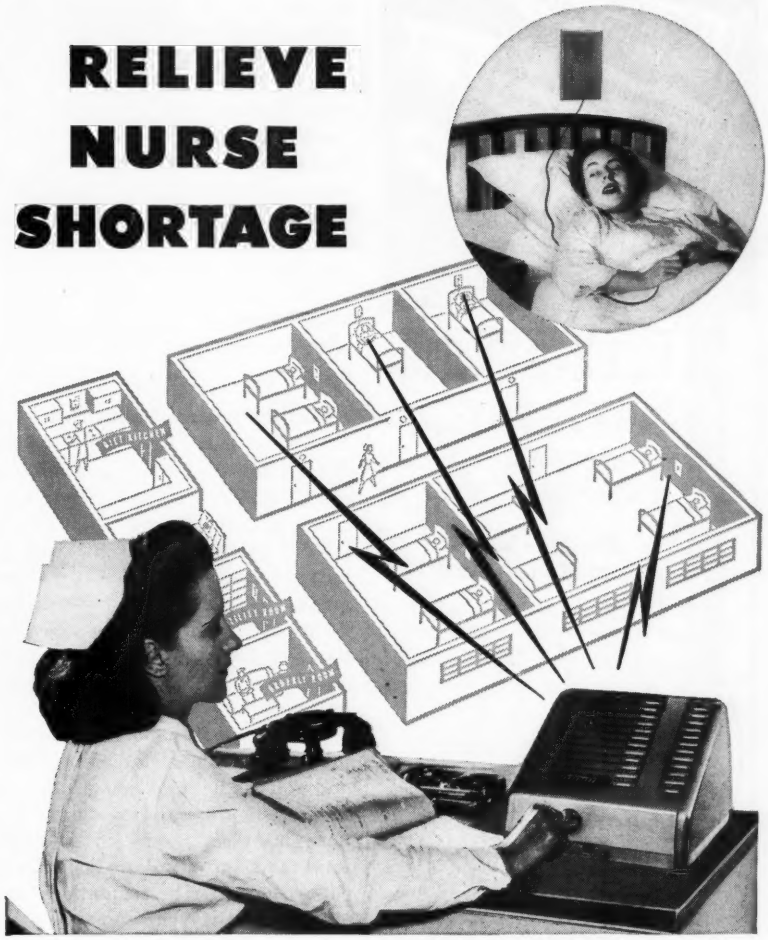

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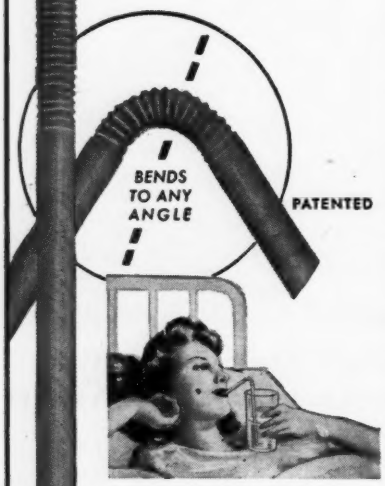

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dents to take training in all fields as part of the basic course, thus adding to its length and cost.

In view of the favorable comments received from many of the administrators whose hospitals are sponsoring or participating in practical nurse training programs, it seems apparent that the indifference and, in many instances, the opposition of hospital administration to this type of nurse education stems from a lack of information about the scope of training for bedside nursing which characterizes most approved programs.

Room for improvement . . In this field as in any other, some schools are not up to standard and there is much room for improvement in curricula and regulations on the state level. Indifference on the part of hospital administration will not improve the school whose graduates do not measure up as members of the hospital nursing staff or bring about improvements in curricula and policies.

On the other hand, hospital administration cannot influence trends and policies without being informed about the training standards that have been set up on the national level and the application of these standards in state regulations and local programs.

In many instances, as pointed out in previous articles by this writer, local programs are finding it desirable to deviate from some of the presently accepted rules and regulations. Some state boards have flexible regulations while others are extremely rigid, permitting little experimentation or deviation.

Few hospital administrators like the title "practical nurse" but as this program has developed, little organized effort has been made on behalf of a more satisfactory title. Six states used the title "trained attendant" or "nursing attendant" in licensure laws passed in earlier years, and still in force. In 1951 Texas and California chose the title "vocational nurse," in the laws adopted licensing a group other than registered nurses. Meanwhile, 28 states have written the title "practical nurse" into licensure statutes, and it's probably too late to turn the tide, although state hospital associations might try to do so if they deem it worth while when licensure legislation is proposed in other states.

What to do . . However, the title isn't nearly as important as are some other aspects of this movement. Here are some things which hospitals can do to help practical nurse education function more effectively to provide competent bedside nurses:

- If your hospital is sponsoring or participating in a training program, do everything possible to recruit as many students as facilities permit and make sure that applicants are carefully screened before being accepted.
- If full enrollment is not achieved or if many students withdraw after entering, determine the causes and correct them insofar as possible.
- If financial reasons prevent students from enrolling or force them to withdraw, get public-spirited individuals or groups to provide scholarships and set up a loan fund.
- Make sure that your school has a good public relations program, including an attractively illustrated bulletin describing its courses and other activities, opportunities for practical nurses, etc. Hire a part-time public relations specialist who knows how to utilize all types of publicity media . . press, radio and TV (if your community has outlets for these), talks in high schools, industrial plants and before all groups which might include prospects as well as groups that might aid recruitment.
- If your hospital is not participating in a training program that is being conducted in your area, you can cooperate in this program by carrying out the above suggestions. Even if you do not anticipate that graduates will join your staff, remember that everything that is done to recruit and train nurses adds to the nurse supply thereby helping all hospitals.
- If you are located in an area that does not have a school for practical nurses, look into the feasibility of establishing a school in your hospital or in cooperation with the local school system. It may be worth while to establish a school even if your state does not yet have licensure, as has been done in many com-

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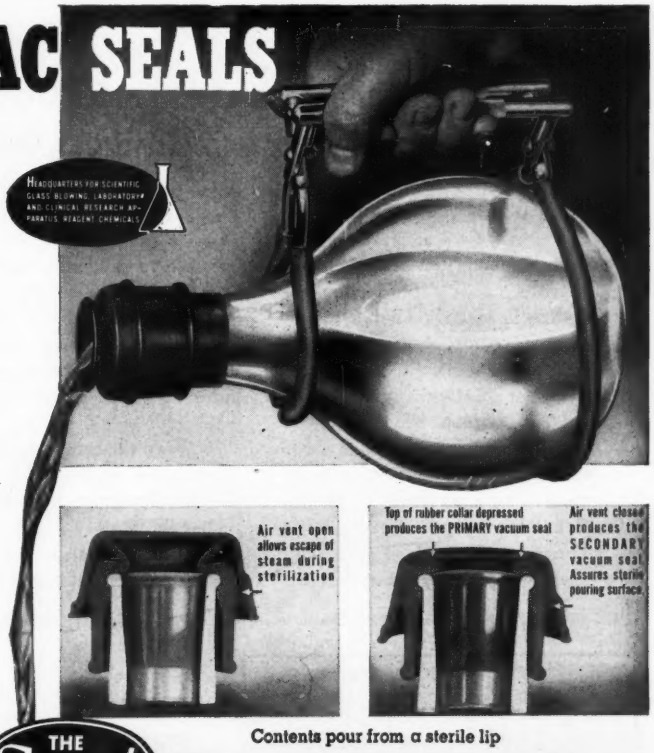
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munities. Lack of a licensure law will not prevent obtaining Federal and state vocational education funds if the program can otherwise qualify.

■ Do not rush in a training program and, of course, the first thing to do if you are located in a state that has licensure is to contact the state board. which has to do with the approval of practical nursing schools, requesting a copy of the state regulations and curriculum and the advice of the board secretary or coordinator. The principal or director of vocational education in your local high school can obtain information from the State Board for Vocational Education about the rules governing allotment of aid for this type of project.

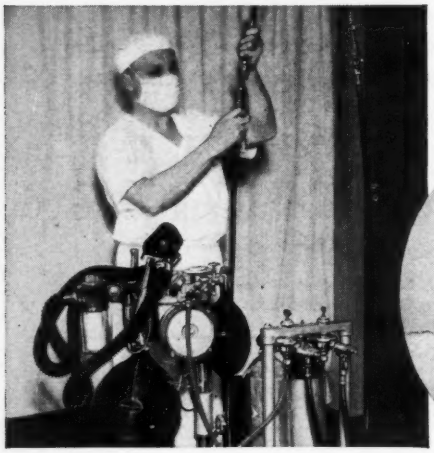
State approval . . Make sure that the program that is set up complies with all of the requirements for state approval if your state has licensure. If you do not have licensure of practical nurses or similar group, it is advisable that the program be set up in accordance with approved standards as recommended by the National Association for Practical Nurse Education and the U. S. Office of Education, as this will facilitate obtaining approval when a licensure law is passed. Accreditation by the NAPNE will be an advantage in recruiting students but is perhaps less essential in a state having licensure, since approval by the state board may be easier to obtain as well as being necessary to enable graduates to qualify for licensure.

If you want to know more about the standards and scope of practical nurse training as recommended by a representative joint committee, send for the two publications issued on this subject by the U. S. Office of Education and available by purchase from the Superintendent of Documents, Government Printing Office, Washington, D.C. The titles are: *Practical Nursing,* Misc. Publication No. 8, and *Practical Nursing Curriculum,* Misc. Publication No. 11.

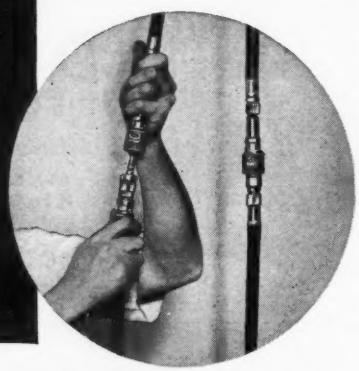
The former contains a detailed analysis of the practical nurse occupation and a detailed outline of practical nurse functions in various areas of nursing service, classified under the headings: "What the practical nurse must be able to do," "What the practical nurse must use," and "What the practical nurse must know."

The bulletin on curriculum won't be of much value without Publication No. 8 because in outlining the curriculum it refers constantly to the analysis of function as published in *Practical Nursing.*

When you have studied these two publications, particularly No. 8, you may want to review the description of courses as published in the catalog of a good professional nursing school to find out what, after



Left — Overhead installation of Schrader "Safety-Keyed" Medical Gas Couplers enables anesthetist to plug directly into lines.



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all, the professional nurse learns and can do that is beyond the realm of practical nurse functioning. After doing this, you'll still feel that you can't get along without some professional nurses on your staff, but you'll probably realize also that your hospital could do a pretty good job of caring for patients if enough trained practical nurses were available to perform all the tasks that have been listed as within their abilities by the top authorities whose names appear in the front of the Office of Education publications as members of the committee responsible for the recommendations offered therein.

Present trend . . Having reached this point in your research, it will be of interest to you to learn that the present trend is to add to the list of procedures which a practical nurse should be taught how to carry out. Among those, which at one time were regarded as beyond the ability of even the professional nurse, are the taking of blood pressure readings, giving fluids intravenously and supervising the administration of oxygen. Illustrations of practical nurses being taught to perform these tasks are found in the bulletins issued by some of top-notch schools. In Washington State, the nursing organizations are on record as urging the teaching, as part of the practical nurse curriculum, of the administering of oxygen, administering of intra-muscular injections, the taking of blood pressure and other advanced procedures.

In addition to those issued by the Office of Education, there are two other publications which will prove helpful to hospital administrators who are interested in setting up a practical nurse school of their own or a program in cooperation with the local school system. There are: *Practical Nurses in Nursing Services,* American Nurses Association, New York 16, and *Practical Nurse Education,* National Association for Practical Nurse Education, New York 21.

Many problems are yet to be solved in order that practical nurse education may be developed and extended to serve to the fullest extent possible the needs of the sick in the hospital and in the community and assume its proper niche among the forces that are working for the betterment of individual and community health.

Hospitals and hospital administration have an important role to play in this development along realistic lines if the hospital is to properly discharge its obligations as a community institution dedicated to the treatment, diagnosis and prevention of disease, and the care of the injured and the newborn. ■

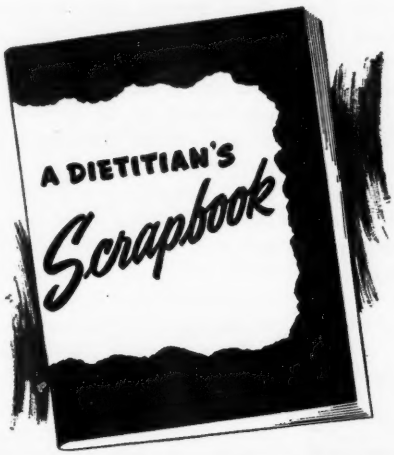
Editors' Note . . The foregoing is the concluding article in a series of six articles by Mrs. Hyde on practical nurse education as being carried out in various states and communities. The series, which began in the February, 1952 issue, has provided one of the most revealing and objective pictures yet presented on this subject.

In-training helps solve nurse shortages

■ IN-SERVICE TRAINING for three months will qualify the auxiliary worker for adequate and efficient performance of nursing service functions, according to Sister Mary Leonard, administrator, Our Lady of Mercy Hospital, Owensboro, Ky., who was a May 29 speaker at an in-service training section of the Catholic Hospital Association convention at Cleveland, O. She pointed out that such a schedule was not easily adhered to, "due to the inadequate salary that can be assured to the individual who devotes her time to this training."

She pointed out that the shortage of personnel in the health fields, increased patient costs and the difficulties in obtaining supplies and equipment have necessitated changing our thinking about the duties of various groups and working out programs to better use the personnel and facilities at hand and obtainable.

The recent licensing law of practical nurses will allow the hospitals more freedom in teaching auxiliary workers the duties they really need them to do to be of assistance to the professional nurse, she declared, and



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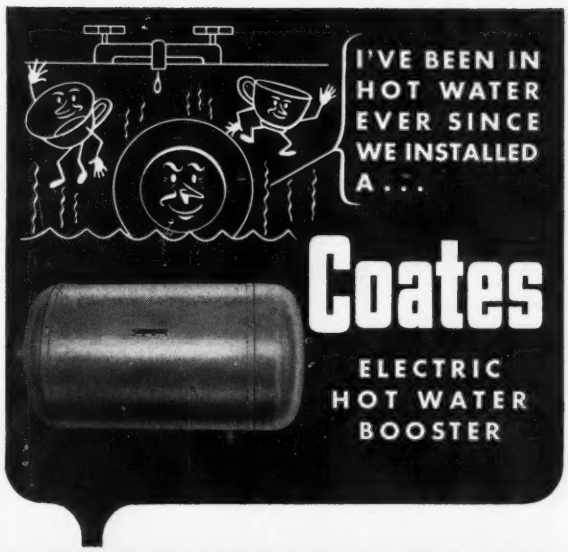

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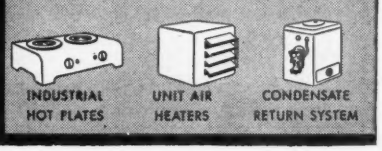

will prevent many auxiliaries from dropping out and taking private cases on their own after receiving some training.

"Auxiliary personnel may do better if trained on the job," concluded Sister Mary Leonard. "It has been shown again and again that one cannot afford not to train employes and that time is saved in the end by so doing."

Good organization . . "What is the impact of good organization on nursing care?" asked Sister M. Dorothea, S.S.C., administrator of Loretto Hospital, Chicago, Ill. She answered her own question by pointing out that "the service a hospital renders can be no better than the people who pool their skills, abilities and interests in a concerted effort to give efficient direct and indirect nursing care to the patient.

"To be exact on this point the general internal problem on the human side is and always has been the relationship of the individual to the group. When the organization of the nursing service is clearly defined each individual therein is fully qualified for her particular job, well oriented and properly supervised, all of which is reflected in the attitudes of the workers and their treatment of the patient.

"Given such a climate the supervisor is freed from routine, time consuming details and is able to give more personal attention and time to visiting all areas of her responsibility. She has fewer interruptions and can then better meet the needs of patients, their families and the personnel. . ."

Improving service . . The following suggestions for the improvement of nursing service were given May 27 by Sister Justina Morgan, administrator, St. Mary's Hospital, Evansville, Ind.:

1. Define present scope of nursing service functions and who is now carrying them out.
2. Define relationships of these functions to other hospital services.
3. Take away from nursing service personnel those things that are not close to the patient, namely, housekeeping, linen room, etc., but provide for joint planning.
4. Retain for nursing service those things that are closest to the patient but provide clerks, etc., to function under supervision to carry on purely clerical functions and less highly trained nurse aides to do routine care for patients and to care for equipment and supplies that are needed for patient care. Supervision must be carefully determined both as to kind and amount.
5. Using principles of good organization with proper consultation for someone well versed in organizational planning, set up an ideal organization for nursing service.
6. Institute better methods of management and patient care procedures.

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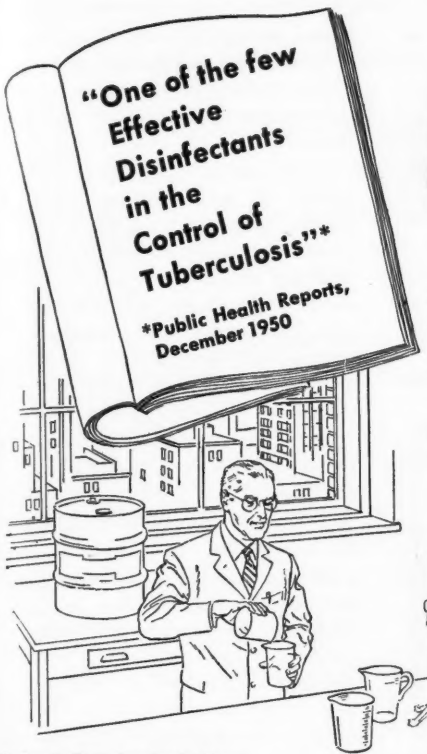

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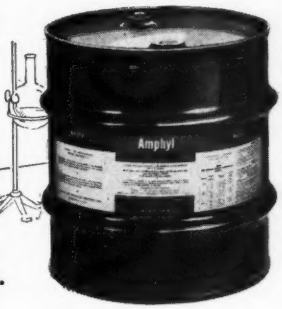

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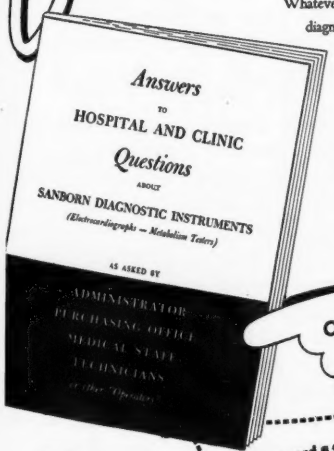

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particular skills, said Sister Baptista, D.C., director of nursing, DePaul Hospital, St. Louis, Mo. These skills are job analysis, interview techniques, industrial psychology, record maintenance and other factors.

The small hospital might use a personnel director on a part time basis, said Sister Mary George Boklage, R.S.M., director of nursing service and operating room supervisor, Our Lady of Mercy Hospital, Mariemont, Cincinnati, O.

Maternity . . A study of women having their first babies, made at the School of Social Service at St. Louis University, was discussed by Miss Lucile Healy, assistant professor of social work there.

The study showed that many of the women expecting their first babies were frightened at the whole idea of being hospitalized and completely lacking in knowledge of understanding of the problem ahead of them.

"Universally, pregnancy is regarded as a normal physiological process and the normalcy of it is stressed by those who have dealings with the pregnant woman," she declared. "Once in the medical setting, however, she is caught up in routine and authoritative handling as though she is, in fact, a patient, that is, an ill person, not normal."

Of this group studied at St. Louis University fourteen were 17 years old, eleven, 18; five, 19; three, 21; two, 20, and one each aged 16, 22, 24, 25 and 29.

Most of them had financial worries, accentuated by the fact that they must give up their jobs and depend on their husbands' meagre earnings. Only six of the group were satisfied with their living arrangements. Because of immaturity, fear, or rebellion most of them were in the last of the second trimester of pregnancy or well into the third before they sought medical care.

She explained that on investigation they tended to believe that pregnancy tends to "wreck" a woman, "either because it breaks down her health or changes her so that she is no longer whole and good and strong." In addition, she said that most of them felt that they would like to have more time to adjust to marriage, while still others had no confidence in their ability to care for a baby properly.

Thirty-four of the 39 studied definitely approved of the idea of group discussion prior to having their babies. Twenty-one wanted more information on how to care for their own health during pregnancy, postpartum period and "convalescence" (18 asked specific questions about actual childbirth).

Miss Healy said that the large number who rejected or who only half-way accepted pregnancy made it seem that "could they first have been seen as women and then as patients, could time have been invested in working with them in both settings, this investment of interest might have paid handsome dividends." ■

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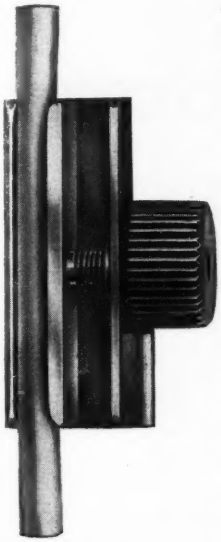

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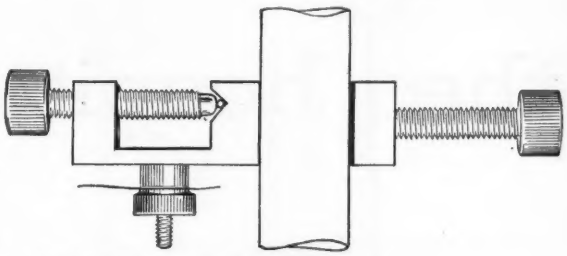

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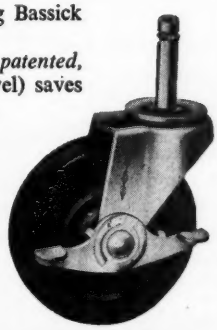

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the hospital pharmacy

Newer approved drugs and drugs under clinical study

by Paul L. Wermer, M.D. Assistant Secretary, Council on Pharmacy and Chemistry • American Medical Association • Chicago

This is section two of a paper which began on page 78 of the June issue. It was read April 28, 1952 before the Tri-State Hospital Assembly's Conference of Hospital Pharmacists in Chicago.

■ A DRUG of less important general application but of importance cosmetically is selenium sulfide. It is employed only externally as a liquid suspension for application to the scalp in the treatment of seborrheic dermatitis and the control of seborrhea sicca (dandruff). It may be useful to a lesser extent in the management of psoriasiform seborrhea, seborrhea oleosa, acne vulgaris and juvenilis, and stopic eczema. It is not effective against ringworm of the scalp due to *Microsporon audouini.*

Selenium sulfide is absorbed through the skin to only a negligible degree. Experimental studies indicate that the amount absorbed is not greater than the traces which may be present in the average diet. Selenium sulfide is highly toxic if taken orally or if given parenterally, and patients should be properly warned against the danger of accidental ingestion. External use has not so far revealed any case of irritation, sensitization, or intoxication.

Dosage. Selenium sulfide is applied externally as a suspension containing 2.5 per cent of the agent. For application to the scalp, the hair should be shampooed first with ordinary soap or other type of cleanser, and rinsed. From 5 to 10 cc. of the suspension is then applied by light massage with a small amount of warm water to make a lather. This is allowed to remain in contact with the scalp briefly, then rinsed and the application repeated.

The agent should remain in contact with the scalp for a total of at least five minutes. The second application should be followed by three or four rinses to remove all traces of the agent. It is recommended usually that such applications be made twice weekly for two weeks and then once weekly or less often as indicated.

Because of its potential toxicity and the danger of accidental poisoning it should be used only after other methods of control have failed.

Para (di-n-propylsulfamyl) benzoic acid . . The kidney is a remarkable yet relatively simple organ. It is made up of several million units called nephrons, each of which consists of a capillary blood vessel tuft or glomerulus resembling a mulberry partially surrounded by an enveloping baglike capsule. The capsule is drained by a U-shaped tubule.

In the glomerulus almost all the dissolved materials in the blood filter out of the capillary tuft into the capsule. Just enough fluid is left to propel the formed elements out of the glomerulus. The fluid in the capsule drains into the tubules where a remarkable reabsorption of solutes and further excretion of metabolites take place.

The reabsorption and further excretion are due to enzyme systems contained within the tubule cells. These systems are often called carrier or transport systems. These transport systems have a special affinity for one or more substances and carry them through the cells lining the tubule in either direction to or from the blood stream and the tubular lumen.

Apparently these systems may be more attracted to one of the several substances it is their special job to excrete. They will first excrete this one substance in preference to all the others which thus remain in the blood stream. Similarly, the systems whose job it is to act as scavengers to pull back into the blood stream useful materials also prefer one of the substances they reabsorb.

Probenecid-para (di-n-propylsulfamyl) benzoic acid or Benemid possesses both qualities. It is preferably excreted by one transport system and preferentially reabsorbed by another. By this preference other materials are returned in the blood stream or are not reabsorbed.

This probenecid is preferentially excreted by the same transport system as penicillin, *p*-aminosalicylic acid, and phenolsulfonphthalein. If present in sufficient quantity probenecid keeps the carrier system so occupied that it cannot excrete the

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other substances. It is reabsorbed into the blood stream by intervention of the same carrier system of enzymes which reabsorbs uric acid.

Therefore if probenecid fully occupies the capacity of the carrier system it cannot transport uric acid, thus preventing tubular reabsorption of urate, increasing its urinary excretion and reducing the serum level of uric acid. Probenecid then can be used as an adjuvant to penicillin or *p*-aminosalicylic acid therapy to increase and prolong their plasma concentrations.

It is also an effective uricosuric agent promoting the elimination of uric acid in the interval treatment of chronic gout. Because it suppresses the excretion of phenolsulfonphthalein (phenol red) PSP which is utilized in a kidney excretion test the degree of suppression of PSP excretion may be used as a clinical guide to the effectiveness of probenecid. Analytic methods are also available for determination of probenecid metabolites in the body fluids.

Probenecid plasma levels of 2 to 10 mg. per 100 cc. maintain effective plasma levels of penicillin and *p*-aminosalicylic acid. The agent is capable of producing a twofold to fourfold increase in plasma levels of penicillin or *p*-aminosalicylic acid over that ordinarily obtained with the same dose.

Probenecid therefore can be used to prolong the effectiveness of orally administered penicillin and to reduce the dose required for adequate therapy by either the oral or intramuscular route. It may enhance the effectiveness of *p*-aminosalicylic acid in tuberculosis by increasing its plasma level above the usual limits attainable with oral administration since large doses cause gastric distress.

Probenecid does not occupy the transport system responsible for the reabsorption of glucose, arginine, urea, or creatinine from the urine, nor does it affect the excretory carrier systems of streptomycin, chloramphenicol, aureomycin, or terramycin. It does raise the plasma concentration of the conjugated sulfonamides, which are biologically inactive, and causes an insignificant increase in the free sulfonamide level which is considered to be therapeutically inconsequential. However, whenever sulfonamides are administered in conjunction with probenecid, it is wise to determine the sulfonamide plasma concentration regularly to avoid possible development of toxic sulfonamide levels.

Probenecid may precipitate an acute attack of gouty arthritis when used as a uricosuric agent in chronic gout. Also, by retarding the urinary reabsorption of urates, probenecid may favor the formation of uric acid stones from urates which tend to crystallize in an acid urine. Colchicine should be administered without discontinuing probenecid to manage acute attacks of gout, and the precipitation of urates can be minimized by maintaining the urine alkaline to litmus. *Salicylates should not be administered in conjunction with probenecid because the therapeutic actions of the two drugs are antagonistic.* Probenecid has no analgesic action and is of no value in the treatment of acute gout.

Probenecid is rapidly absorbed into the blood stream following oral administration and it is promptly eliminated in the kidney by glomerular filtration. However, its reabsorption by its carrier system in the renal tubules is so great that little or none appears in the urine. It is destroyed slowly in the body and its metabolic end products are only slowly excreted in the urine.

Following a single oral dose, a determinable and functionally useful plasma concentration persists in the dog for longer than 44 hours. A high therapeutic index has been demonstrated in a variety of laboratory animals. Although probenecid is well tolerated in man and is of low toxicity at useful dosages, occasionally patients may experience nausea. This may be overcome by reduction of the daily dosage. Rarely, allergic sensitivity may be manifested by the appearance of a dermatitis, but such reactions are relatively rarer than following the administration of antibiotics or chemotherapeutic agents. If a rash appears, therapy with probenecid should be discontinued until the cause of the reaction can be determined.

Probenecid obviously will serve no useful purpose in the presence of known renal impairment; its rapid accumulation in the plasma may cause nausea or other toxic symptoms. Even in the presence of renal damage, however, probenecid does not exhibit any damaging action on the kidney.

Dosage. Probenecid is administered orally. As an adjuvant to penicillin therapy of severe infections such as subacute bacterial endocarditis and staphylococcic osteomyelitis, the total daily dosage in absence of renal diseases is 2 Gm. given in four divided doses. The dose should be reduced for older persons in whom renal impairment is more likely to be present.

When impairment is sufficient to retard the tubular excretion of penicillin, probenecid is not necessary and may not be tolerated. When used in conjunction with penicillin therapy of children, the daily dosage of probenecid is calculated on the basis of 25 mg. per kilogram of body weight.

The dosage of probenecid when used with *p*-aminosalicylic acid is similar and subject to the same precautions. The phenolsulfonphthalein (phenol red) excretion test employed by the intravenous (15-minute) method can be used as an index of effective plasma concentrations of probenecid. The renal clearance of phenol red is reduced to approximately one-fifth of the normal rate with adequate dosage of probenecid.

As a uricosuric agent in chronic gout, a single daily dose of 0.5 Gm. is recommended for one week, then increased to 1 Gm. daily in two divided doses. This is usually the maximum tolerated maintenance dose because renal impairment is common in patients with gout. In certain patients it may be possible to increase the total daily dosage to 2 Gm., given in four divided doses, to obtain optimal excretion of uric acid. The urine can be maintained alkaline to litmus with doses of 5 to 7.5 Gm. of sodium bicarbonate or potassium citrate, and the patient's acid-base balance should be checked regularly to avoid systemic alkalosis.

Disulfiram . . The recent release of disulfiram, or Antabuse, for prescription use prompts a review of

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its attributes. Disulfiram is tetraethylthiuram disulfide. It is marketed in the form of scored tablets each containing 0.5 Gm. for oral administration as an adjunct in the treatment of chronic alcoholism.

The drug was first used in Denmark as a vermifuge, where, by chance, observation was made that the drug produced highly unpleasant reactions when taken prior to ingestion of a moderate quantity of alcohol. This led to its use as an adjunct in the psychotherapeutic management of chronic alcoholism. The generic name disulfiram has been adopted for the International Pharmacopoeia by the World Health Organization.

Disulfiram interferes with "normal metabolic degraduation of alcohol in the body preventing oxidation of acetaldehyde to carbondioxide and water." Consequently the acetaldehyde concentration in the blood becomes significantly higher following ingestion of alcohol than when the same amount of alcohol is given to persons who have not received the drug. Perfusion experiments indicate that the principal effect of the drug is upon enzyme systems of the liver. It does not affect the rate of alcohol elimination from the body.

Since disulfiram is slowly absorbed and excreted from the intestinal tract, it must be taken at least 12 to 24 hours prior to a test dose of alcohol in order to produce the desired effect. Only about 20% of a 2 Gm. dose is excreted in the feces during the first two or three days following administration and none is found in the urine.

Symptoms have followed the ingestion of alcohol seven to eight days after a single dose of 1.5 Gm. of the drug, indicating that it has a prolonged effect. The characteristic signs and symptoms following ingestion of alcohol are similar to those observed after intravenous administration of acetaldehyde. They usually begin within 5 to 15 minutes in the following order: flushing, sweating, palpitations, dyspnea, hyperventilation, accelerated pulse rate, fall in systolic and diastolic blood pressure, nausea, and ultimately vomiting.

Nausea is generally experienced 30 to 60 minutes after appearance of cardiovascular symptoms. Drowsiness follows, usually with complete recovery after sleep. The intensity and duration of symptoms during the reaction to alcohol depend on the dosage of disulfiram, the amount of alcohol taken, and the individual response of the patient.

All types of alcoholic beverages (including alcoholic medicinal preparations and those applied topically whose fumes may be inhaled) will produce a reaction in patients treated with disulfiram if the blood alcohol concentration is increased to as little as 5 to 10 mg. per 100 cc. A blood alcohol level of 50 mg. per 100 cc. produces full signs and symptoms and unconsciousness usually occurs when the blood alcohol level reaches 125 to 150 mg. per 100 cc.

Triple discovery . . Robert Koch, the German bacteriologist, was the first research scientist to isolate and describe the anthrax bacillus, the tubercule bacillus, and the comma-shaped bacillus responsible for the deadly cholera plagues.

The drug is not curative of itself; its use in the management of chronic alcoholism requires the consent and full knowledge of the patient coupled with the application of psychotherapeutic measure, designed to rehabilitate the patient and correct the underlying maladjustment.

At best disulfiram is but a restraint because of the unpleasant aftermath to an alcoholic debauch. Experienced observers feel it has but a small part to play in the eventual treatment of alcoholism because it does not attack the underlying cause. The patient may discontinue the drug and escape from its deterrant action or may disregard the unpleasant effects and ingest enough alcohol to do himself harm. The drug is valueless and actually dangerous in the treatment of acute alcoholism.

Before instituting treatment patients should not have consumed any alcoholic beverage for at least 24 hours. Disulfiram should never be administered when the patient is intoxicated.

Dosage: Because neurologic changes have been observed in animals and toxic psychoses have been observed with larger doses in human beings, it is best to keep the initial dosage of disulfiram at 0.5 Gm. or less daily for the first two or three weeks; following this period the recommended maintenance dosage is 0.25 Gm. daily.

Disulfiram is of low toxicity when used in the recommended dosage and no deaths have been reported which are attributable to the drug alone. The alcohol test is usually omitted in the presence of the following conditions: diabetes mellitus, myocardial failure or coronary disease, pregnancy, goiter, epilepsy, cirrhosis of the liver, and chronic or acute nephritis.

Similar caution should be exercised when addiction to narcotics is superimposed on alcoholism. When sedation is required, strict supervision is necessary to prevent the development of habituation to barbiturates as a substitute for alcoholism. There is also some evidence to indicate that the agent prolongs the action of barbiturates so that it is best to avoid sedatives of this group, especially intravenously.

Disulfiram should not be used in patients recently treated with paraldehyde, and paraldehyde should not be given to patients treated with disulfiram. Some patients receiving the drug complain of mild drowsiness, fatigability, impotence, headache, or peripheral neuritis, but such symptoms tend to subside with continuation of the drug at a reduced dosage.

Unduly severe and alarming reactions to alcohol in patients on Antabuse therapy have been reported in the literature. These consist chiefly of cardiovascular complications including profound hypotension, cardiac arrhythmiz, electrocardiographic evidence of myocardial ischemia, and even myocardial infarction. Usually these have been caused by excessive trial doses of alcohol or by surreptitious drinking during the initial stages of treatment.

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of continuous medical supervision. Physicians should warn the patient against drinking during treatment and instruct relatives concerning the danger of secret administration of the drug because of the consequences of overdosage.

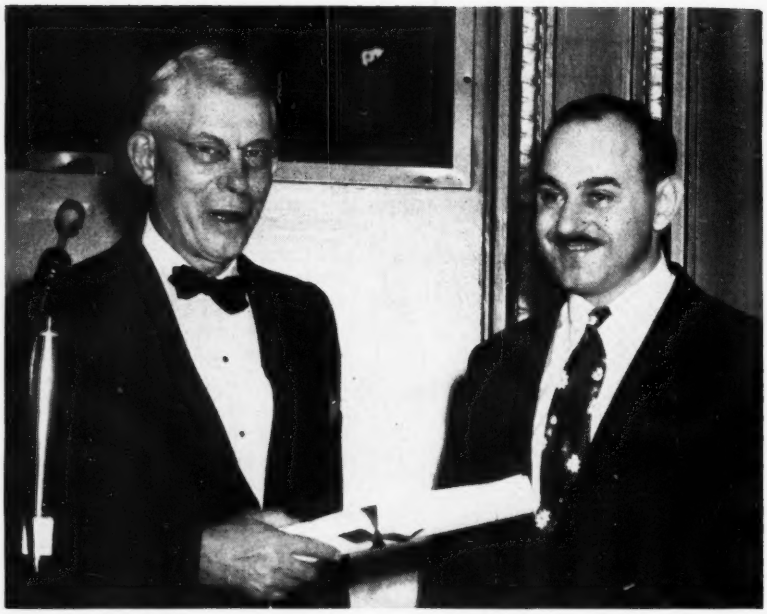
Measures which have been suggested to control or lessen the severity of alarming reactions include the intravenous and oral administration of ascorbic acid in doses of 1 Gm., inhalation of oxygen or a mixture of 95% oxygen and 5% carbon dioxide, and parenteral administration of ephedrine sulfate.

It has been further suggested that every patient under treatment should carry an identification card to that effect, indicating the symptoms most likely to occur following consumption of alcohol, together with the name of the physician or institution to be called in case of emergency. Recently it has been reported that physicians should be on guard against severe personality changes which may be encountered as a concomitant of the sudden withdrawal of alcohol imposed by Antabuse, particularly when the drug is administered against the wishes of the patient.

Physicians who are unwilling or unable to institute other appropriate measures for the physical, emotional, and social rehabilitation of the alcoholic should not prescribe the drug. Likewise, patients who are unwilling, or for reason beyond the effect of the drug are unable, to cooperate, should not be placed on therapy with Antabuse.

Without a sincere desire to stop drinking and to follow the treatment as prescribed by the physician, the drug alone provides little chance for a cure. Under such circumstances it may do more harm than good. As with other aids in the management of chronic alcoholism, ultimate success depends on correction of the underlying maladjustment of the individual. It is concluded that Antabuse may become established as a useful adjunct in the management of selected and adequately supervised cases of chronic alcoholism.

This concludes section two of Dr. Wermer's article on new drugs. The third instalment will appear in an early issue.



Dr. Seymour Lieberman . . on the right, of Memorial Hospital, New York, and assistant professor, biological chemistry, Columbia University, receives 1952 Ciba Award for work in identifying steroid compounds isolated from urine. Presentation is made by Dr. Edward A. Doisy, St. Louis University

new pharmaceuticals

Co-Pyronil . . a new antihistaminic combination has been recently prepared by the Lilly Research Laboratories. Co-Pyronil was shown by animal tests to have a longer duration of effect than that of any other known antihistaminic. During the 1951 hay-fever season, research clinicians reported superior results in an impressive majority of cases. Side-effects on effective therapeutic doses were said to be negligible. The slow onset of action with drug is overcome by the combination of 15 mg. of 'Pyronil' with fast-acting Thenylpyramine and Cyclopentamine. The resulting formula ('Co-Pyronil') thus gives prompt action followed by prolonged relief.

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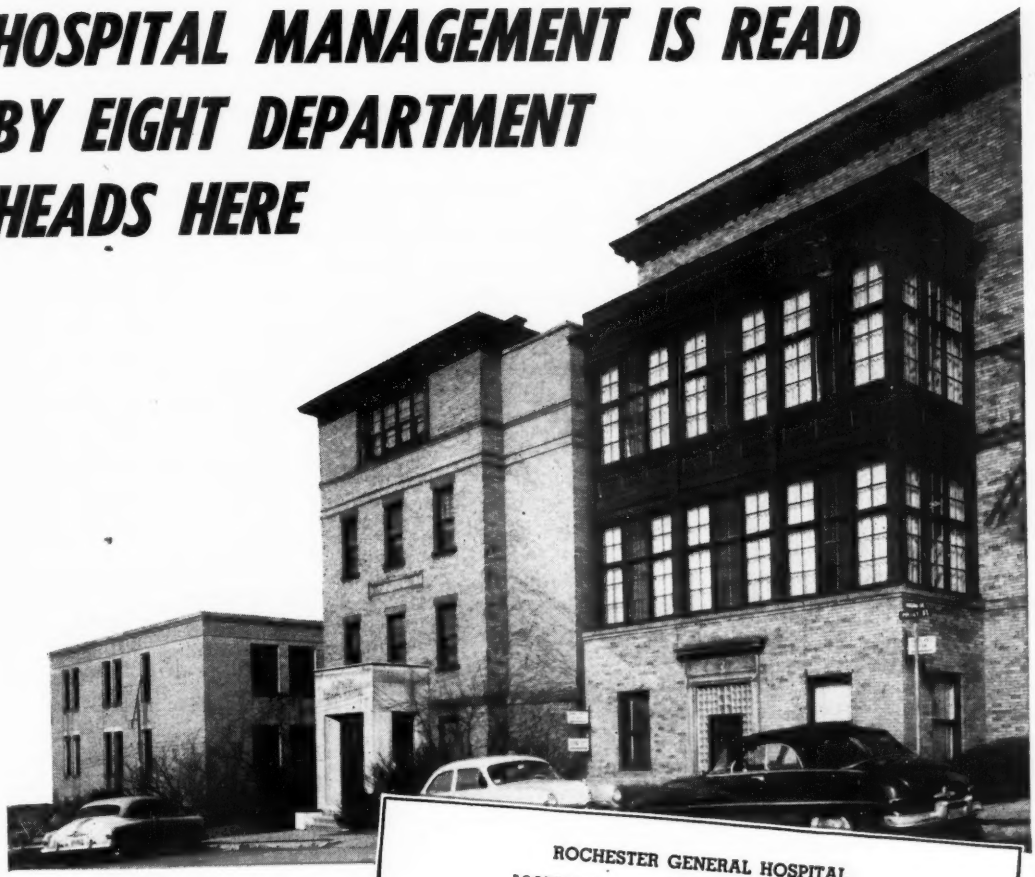

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Credit Manager
Medical Record Librarian
Housekeeper
Maintenance Supervisor
Laundry Manager
Dietitian

Rochester General is in the process of expanding from 171 beds to 275 - many of the problems in conjunction with this growth are more readily solved, by keeping abreast of the current hospital situation, through careful review of hospital magazines. HOSPITAL MANAGEMENT is a must on our educational program.

Sincerely yours,
Wilson E Tucker
Wilson E. Tucker
Administrator

Hospital Management

200 EAST ILLINOIS STREET • CHICAGO 11, ILLINOIS

READ MOST BY MOST HOSPITAL EXECUTIVES

needs of the patient. Cortrophin, the first ACTH preparation in the world, was first marketed by Organon in 1945.

"Child Proof" aspirin . . was announced recently by the Armour Laboratories of Chicago. Under the Armour trade name of Crystar, the new product does away with the major objections which make it hard for mothers to give aspirin to children as prescribed by the doctor. Crystar is tasteless, not bitter like common aspirin. No flavoring has been added, so Crystar can readily be added to familiar liquids like milk and orange juice without objection. Children aren't tempted to seek it in the medicine chest without mother's knowledge and eat enough to poison themselves believing it is candy, because of the new "tasteless" idea. One packet, or one grain, will dissolve readily in as little as two teaspoonsful of water, juice or milk.

Cotinazin (isonicotinic acid hydrazide) . . has been released now by Charles A. Pfizer & Co., Inc. as a result of clearance by the Federal Food and Drug Administration of the firm's new drug application for this product. Clinical trials of the new anti-tuberculosis drug are now in progress throughout the world. Pfizer revealed that by the end of 1952 their production of Cotinazin will reach 100 million tablets per month if demand warrants, and it will be sold in bulk to pharmaceutical firms here. Although some concern has been expressed over the supply of hydrazine, an essential chemical for synthesis of Cotinazin, John E. McKeen, president of Pfizer, states that the Pfizer Company will have ample quantities of this substance to fill the needs of its planned production program.

Dromoran Hydrobromide 'Roche' . . the new synthetic, morphine-like narcotic, is now available in large-size bottles of 1,000 oral tablets, 5 mg each, according to Hoffmann-La Roche, Inc. Dromoran is now used extensively to replace morphine for longer-lasting relief from severe pain. According to the manufacturer, Dromoran has been highly successful in the control of postoperative pain, relief of severe and prolonged pain in inoperable cancer, and for pain relief in other serious illness and injuries.

'Benemid' Probenecid . . a new agent for treating gout, is available to doctors across the nation in tablet form, according to Sharp & Dohme, Incorporated, who say it has passed rigid clinical tests, and is designed to relieve gout-sufferers. The new compound is a simple synthetic chemical, stable, sparingly soluble in water, and almost tasteless. A benzoic acid derivative, the white crystalline material's chemical name is p-(di-n-propylsulfamyl) benzoic acid.

Cortone . . the Merck brand of cortisone, has been made available in a 5 mg tablet size to enable physicians to establish a minimum maintenance dose in rheumatoid arthritis more conveniently. Used alone or with the 25 mg tablet already supplied, this new size is said to make it possible to arrive at a dosage of Cortone suitable to the individual patient's requirements.

Synkayvite-CB lozenges 'Roche' . . are new, cherry-flavored, candy-like lozenges which provide vitamin-K compound for prevention of delayed hemorrhage, vitamin C for promotion of wound healing and B-complex factors for reinforcing the nutritional status of the patient. Synkayvite-CB lozenges are said to be especially valuable in young patients following tonsillectomy when swallowing may be difficult.

Dihydrostreptomycin . . is the name of a new penicillin antibiotic product with the trade name of Penstrep "4: ½". It has been made available by Merck & Co., Inc. It contains one half the crystalline dihydrostreptomycin of its companion product, Penstrep "4:1," marketed last October. Combined penicillin-dihydrostreptomycin therapy has been found effective in the treatment of mixed infections, some cases of bacterial endocarditis, urinary tract infections, tuberculosis when accompanied by susceptible secondary infections and other infections due to organisms susceptible to either antibiotic.

Chloresium ointment . . a newcomer in chlorophyll therapy, shortens the healing time on difficult lesions and is effective in the postoperative care of pilonidal cysts. In addition to providing freedom from odors which bother patient and physician, the chlorophyll ointment is said to facilitate indentification of hidden sinus tracts through contrast with the healthy tissue. Prolongation of treatment through neglect of pathological extension is thus more easily avoided.

Solution Intravenous Veriloid . . supplied in 5cc and 20cc ampules has been announced by Philip K. Bates, president of Riker Laboratories, Inc. The product is a stable solution, said to be capable of producing an immediate, sustained drop in blood pressure, thus making it ideal for the treatment of hypertensive states accompanying cerebral vascular disease, malignant hypertension, and hypertensive crisis. Its acceptance by the American Medical Association has recently been announced.

Hexamethonium chloride . . has shown a reduction of blood pressure and relief of symptoms among 103 hypertensive patients, according to Drs. K. S. Grimson, E. S. Orgain, C. R. Rowe, Jr., and H. A. Sieber, of Duke University. The doctors state that the new product given orally may well prove a valuable drug for many patients with hypertension. The drug is now available for oral use, in tablet form, under the trade name of Methium, manufactured by Chilcott Laboratories.

Bicillin for aqueous injection . . has been indicated as a new form of penicillin which may prevent recurrences of rheumatic fever, according to the results of clinical studies conducted at Irvington House, Irvington, N. Y. with children convalescing from rheumatic carditis. The penicillin compound is said also to be useful to prevent complications from secondary bacterial infections. It may also be used to prevent infection following tonsillectomy and tooth extraction, as well as in congenital heart disease and minor surgery.

Trends in the field of biological products

by M. V. Veldee, M.D.*

■ I HAVE BEFORE ME an excerpt from a letter which was written in 1717. It is from Lady Mary Wortley Montagu, who was at that time living in Adrianople. It is written to her friend Sarah Chiswell of England. She describes an "invention of ingrafting" which was then in vogue in Constantinople.

Her description of this procedure is as follows; "there is a set of old women who make it their business to perform the operation every autumn, in the month of September, when the great heat is abated. People send to one another to know if any of their family has a mind to have the smallpox; they make parties for this purpose, and when they are met, the old woman comes with a nut-shell full of the matter of the best sort of smallpox, and asks what vein you please to have opened.

"She immediately rips open that you offer to her with a large needle and puts into the vein as much matter as can lie upon the head of her needle. . ."

Largely due to the influence of Lady Montagu this method of inoculating against smallpox was introduced to Western Europe.

First in U.S. . . Historical record credits Dr. Zabdiel Boylston of Boston with having performed the first inoculation with the virus of smallpox in this country. In the year 1721 he inoculated his 13 year old son and two house servants. This procedure no doubt represents the first intentional use of a live virus to establish active immunity.

Knowledge of an immunological relationship between cowpox and smallpox prevailed among farmers in England as early as 1774. By 1796 Jenner had conclusively demonstrated through logical and scientific methods that by becoming infected with the mild disease of cowpox man developed full protection against the serious and often fatal disease smallpox.

This innocuous procedure was first used in this country on July 8, 1800 by Dr. Benjamin Waterhouse of Boston when he vaccinated his son Daniel. Later the boy failed to contract smallpox when inoculated with virulent matter by Dr. Zabdiel Boylston. These carefully controlled studies by Jenner represent the first use of a relatively avirulent living virus for human immunization.

Diphtheria antitoxin . . The discovery of diphtheria antitoxin was announced in 1890 by Behring and Kitasato. Plans were perfected in 1894 by Dr. William H. Park of the New York City Bacteriological Laboratories to begin production of diphtheria antitoxin in the horse. Actually production was begun in January 1895 and the first patient treated soon thereafter at the Willard Parker Hospital. By April of that year the antitoxin was offered for use by any physician in New York City. This represents the first large-scale production and use of diphtheria antitoxin in this country.

Research work on the development of diphtheria toxin-antitoxin followed closely the work with diphtheria antitoxin. In this country it was largely due to the pioneering work of Park and Zingher, beginning in 1913, which led to the general use of this product for active immunization. We have in this instance the first use of a sterile bacterial filtrate as an antigen in establishing active immunity.

In 1896 Pfeiffer and Kolle injected killed typhoid bacilli into two persons. However, credit is generally given to Sir Almroth Wright who published his first work the same year and thereafter energetically followed with field studies involving the injection of large numbers of British troops.

Major Russell of the United States Army pioneered along these lines in this country. We have in the work of Wright and later Russell the first use of a killed bacterial culture as an antigen in immunization against a specific disease.

Initial successes . . These four events are of historical importance in the field of biologics. They represent the initial successes in the application of the newly developing knowledge in the field of bacteriology and immunology to the prevention and cure of infectious diseases. However, it has not always been possible to prevent the introduction of new biologics until adequately controlled studies could demonstrate their value.

Largely due to the influence of Sir Almroth Wright and those associated with him at St. Mary's hospital, bacterial vaccines soon got completely out of hand. Antogenous vaccines became the vogue for nearly every conceivable infection. The commercial manufacturers of biologics soon followed by preparing stock vaccines of nearly every description.

Single strain vaccines led to multiple strains vaccines and too often without any regard to the antigenic properties of the bacteria used. In some instances even the etiological relationship between the bacterial strains used in the vaccine and the disease which it was expected to cure or prevent was entirely ignored.

Uncertainty and exploitation . . The spectacular therapeutic results obtained with diphtheria antitoxin in the treatment of diphtheria stimulated research in the field of antitoxins. It was found that not all pathogenic bacteria produced true exotoxins which, like diphtheria toxin, were capable of stimulating antitoxin formation. This led in time to the study of anti-bacterial serums for the treatment of disease.

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*Dr. Veldee is now medical director of Hyland Laboratories, Los Angeles 27, Calif. When he delivered this paper before the American Pharmaceutical Manufacturers' Association he was chief of the Laboratory of Biologics Control, National Institutes of Health, Bethesda, Md.

Management returns through cost control

by **Katherine Hart, M.S.** Professor and Head of Department of Institution Administration • Michigan State College

■ I AM NOT GOING to give you a short 40 minute course in cost accounting or food control. What I shall do in this paper is present some ideas about the importance and the use of figures in management and summarize a few cost control techniques that we are using at Michigan State College.

Let us see what we mean by cost control. Many accountants feel that you can break cost control into two parts. Cost information is useful and costs are used by management, first, to make intelligent plans. That is important.

The second function of cost information in management is the aspect of control; that is, to keep a running check upon operations, to get some information about what is going on . . not so much that you have the information to get the answers, but from the point of view of getting the data so you can ask some intelligent questions . . questions on what is happening, questions on the necessity of a corrective action of some kind, and questions about the kind of a corrective action that should be taken, questions that may have a bearing on the profit margin.

What is profit? . . In America all of use have talked a great deal about the free enterprise system and we have talked a great deal about the importance of profit in that system. However, it is not necessarily the function of management to produce profit. Profit is one of the things we hope for; it is one of the reasons why we keep in business; but the function of management is to operate a business efficiently, and by efficiently we mean as economically and carefully as it can possibly be run to achieve the objectives which have been set up.

From this we can see that the basic notions of cost control are not necessarily a matter of beating down costs and pushing up prices to increase profit margins. Often prices cannot be pushed up because, as you know, prices are set by competition; they are set by other means. The achievement of profit is largely one of reducing costs. And costs ought to be minimized, anyway, as a matter of efficient management. Therefore when we speak of cost control we are talking about a basic responsibility of management whether it be in a profit making enterprise, a non-profit making enterprise, or any other kind of situation, because we are concerned with cost control for cost reduction.

Self-liquidating . . Now why are we at Michigan State College vitally interested in cost control? The answer is very simple, an answer that is interwoven with an administrative building program for college residence halls, recreational, housing and food service facilities, and conference accommodations. These projects are all self-liquidating and have been constructed and financed without expense to the general public (as the little green and white signs proclaim to all campus comers).

Twenty years ago when I came to Michigan Agricultural College as a dietitian for one of the two girls' dormitories there were no little green and white signs, neither was there any special pressure for controlling costs. The college enrollment was less than 3,000, and outside of Michigan few people were aware that Michigan Agricultural College existed. I grew so weary of explaining to my friends that M.A.C. and the university at Ann Arbor were not one and the same institution that I finally relaxed and let future events complete the differentiation.

Life for the dietitian on the East Lansing campus was relatively untroubled back in 1932. The depression, that great leveller, swept away any personnel problems that might have been lurking in the corners. The college administration asked that the food service revenue cover

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This paper was read April 29, 1952 before the Tri-State Hospital Assembly Conference of Dietitians in Chicago.

monthly menus hm . . . August 1952

H = house (normal or general) diets
S = soft diets
P = personnel menus

		Fri. Aug. 1	Sat. Aug. 2	Sun. Aug. 3	Mon. Aug. 4	Tues. Aug. 5	Wed. Aug. 6	Thurs. Aug. 7	Fri. Aug. 8
BREAKFAST . .	H	Kadota Figs Cold Cereal Scrambled Eggs Toast	Grapefruit Juice Hot Cereal Shirred Egg Toast	Fresh Peaches—Cream Cold Cereal Link Sausage Swedish Rolls	Baked Rhubarb Cold Cereal Scrambled Eggs Toast	Fresh Grapes Cold Cereal 3-Minute Egg Raisin Toast	Orange Slices Cold Cereal Bacon Curls Pineapple Coffee Cake	Bananas—Cream Cold Cereal Baked Egg Toast	Grapefruit Half Cold Cereal Omelet Toast
	S	Apricot Nectar Hot Cereal Scrambled Eggs Toast	Grapefruit Juice Hot Cereal 3-Minute Egg Toast	Orange Juice Hot Cereal Crisp Bacon Toast	Cherry Nectar Hot Cereal Scrambled Eggs Toast	Grape Nectar Hot Cereal 3-Minute Egg Toast	Blended Fruit Juice Hot Cereal Crisp Bacon Toast	Mashed Bananas in Orange Juice Hot Cereal Baked Egg Toast	Grapefruit Juice Hot Cereal Omelet Toast
	P	Kadota Figs Cold Cereal French Toast—Jelly	Grapefruit Juice Hot Cereal Shirred Egg Toast	Fresh Peaches—Cream Cold Cereal Link Sausage Swedish Rolls	Baked Rhubarb Cold Cereal Scrambled Eggs Toast	Fresh Grapes Cold Cereal 3-Minute Egg Toast	Orange Slices Cold Cereal Bacon Curls Pineapple Coffee Cake	Bananas—Cream Cold Cereal Pancakes—Syrup	Grapefruit Half Cold Cereal Fried Egg Toast
LUNCH . .	H	Spiced Ham & Vegetable Omelet Whole Wheat Muffins—Jam Tossed Salad Greens Watermelon Slice	Cubed Steak Sandwich Roast Potato Balls Pickle Relish Salad Caramel Fruit Eclair	Oven Fried Chicken Candied Yams Braised Celery Cranberry-Orange Salad Peanut Brittle Ice Cream Sundae	Vegetable Soup Spaghetti Italienne with Tiny Meat Balls Fruited Gelatine Salad Mocha Dot Cake	Chicken Wings with Gravy Chantilly Potatoes Endive-Tomato Salad Fruit Bars	Consomme Cold Veal in Tomato Aspic Baked Potatoes Boston Brown Bread Cantaloupe a la Mode	Salami Stuffed Pepper Escalloped Egg Plant Bing Cherry Salad Lemon Filled Cookies	Mongole Soup Tuna Fish & Cabbage Tossup Harvard Beets Poppyseed Twists Frosted Fruit Cocktail
	S	Strained Soup Plain Omelet Beet Puree Canned Pear	Strained Soup Macaroni au Gratin Bu. Asparagus Tips Bananas-Custard Sauce	Jellied Consomme Roast Chicken Mashed Potatoes Bean Puree Vanilla Ice Cream	Strained Soup Eggs a la Goldenrod on Rusk Diced Carrots Gelatine Cubes—Wh. Cr.	Strained Soup Sliced Chicken Chantilly Potatoes Maple Custard	Consomme Stuffed Baked Potato Bu. Peas Chocolate Ice Cream	Strained Soup Creamy Rice Bean Puree Prune Whip	Strained Soup Creamed Tuna on Toast Beet Puree Frosted Fruit Cocktail
	P	Spiced Ham & Vegetable Omelet Whole Wheat Muffins—Jam Tossed Salad Greens Watermelon Slice	Cubed Steak Sandwich Roast Potato Balls Pickle Relish Salad Caramel Fruit Eclair	Oven Fried Chicken Candied Yams Braised Celery Cranberry-Orange Salad Peanut Brittle Ice Cream Sundae	Vegetable Soup Spaghetti Italienne with Tiny Meat Balls Fruited Gelatine Salad Mocha Dot Cake	Wieners—Buns Potato Salad Hot Slaw Fruit Bars	Consomme Baked Pork & Beans Boston Brown Bread Cantaloupe a la Mode	Salami Stuffed Pepper Fr. Fr. Egg Plant Bing Cherry Salad Lemon Filled Cookies	Mongole Soup Tuna Fish & Cabbage Tossup Harvard Beets Poppyseed Twists Frosted Fruit Cocktail
DINNER . .	H	Fillet of Lemon Sole—Tartar Sauce Bu. Crumb Potatoes Cold Tomatoes Cole Slaw Washington Pie	Braised Short Ribs of Beef Parslied Bu. Potatoes Stuffed Zucchini Pickled Peach Salad Gingerbread—Cherry Sauce	Cheese-Bacon-Tomato Rarebit Stuffed Baked Potato Asparagus-Egg Salad Raspberry Bavarian Cream	Stuffed Pork Roast—Apple Sauce Potato Cakes Fresh Spinach Mounds Carrot Slaw Pineapple Surprise	Hamburger Steak Cottage Potatoes Julienne Beets Pickle-Radish Salad Boysenberry Cobbler	Lamb Roast—Onion Gravy Whipped Potatoes Creole Squash Garden Salad Four Fruit Pudding	Minute Steak Grilled Potato Slices & Tomato Half Slivered Carrots Rhubarb Brown Betty	Broiled Smelts—Tomato Sauce Escalloped Potatoes Frenched Green Beans Lettuce Wedge—Herb. Dr. Peach Tapioca
	S	Strained Soup Baked Whitefish Bu. Potatoes Bu. Carrots Sherbet	Strained Soup Cubed Steak Riced Potatoes Summer Squash Fruit Whip	Strained Soup Cottage Cheese Bu. Peas Baked Custard	Strained Soup Broiled Veal Pattie Duchess Potatoes Spinach Puree Canned Peach	Strained Soup Broiled Beef Pattie Riced Potato Bean Puree Fruit Cocktail	Strained Soup Broiled Lamb Pattie Whipped Potatoes Baked Squash Peaches-Custard Sauce	Strained Soup Stewed Chicken Potato Puff Slivered Carrots Rhubarb Brown Betty	Strained Soup Baked Halibut Escalloped Potatoes Bu. Peas Peach Tapioca
	P	Fillet of Lemon Sole—Tartar Sauce Bu. Crumb Potatoes Cold Tomatoes Cole Slaw Washington Pie	Braised Short Ribs of Beef Parslied Bu. Potatoes Stuffed Zucchini Pickled Peach Salad Gingerbread—Cherry Sauce	Cheese-Bacon-Tomato Rarebit Lyonnaise Potatoes Asparagus-Egg Salad Raspberry Bavarian Cream	Stuffed Pork Roast—Apple Sauce Potato Cakes Fresh Spinach Mounds Carrot Slaw Pineapple Surprise	Hamburger Steak Cottage Potatoes Julienne Beets Pickle-Radish Salad Boysenberry Cobbler	Lamb Roast—Onion Gravy Whipped Potatoes Creole Squash Garden Salad Four Fruit Pudding	Smothered Steak Grilled Potatoe Slices & Tomato Half Slivered Carrots Rhubarb Brown Betty	Broiled Smelts—Tomato Sauce Escalloped Potatoes Frenched Green Beans Lettuce Wedge—Herb. Dr. Peach Tapioca

monthly menus hm . . . August 1952

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		Sat. Aug. 9	Sun. Aug. 10	Mon. Aug. 11	Tues. Aug. 12	Wed. Aug. 13	Thurs. Aug. 14	Fri. Aug. 15	Sat. Aug. 16
BREAKFAST . .	H	Tomato Juice Hot Cereal Poached Egg Toast	Honey Dew Melon Cold Cereal Crisp Bacon Sweet Rolls	Prunicot Cold Cereal Shirred Egg Toast	Orange Tidbits Hot Cereal Scrambled Eggs Toast	Peaches—Cream Cold Cereal 3-Minute Egg Raisin Toast	Cantaloupe Hot Cereal Bacon Curls Danish Coffee Ring	Grapefruit Half Hot Cereal Baked Egg Toast	Stewed Apricots Cold Cereal Omelet Toast
	S	**Tomato Juice Hot Cereal Poached Egg Toast**	**Peach Nectar Hot Cereal Crisp Bacon Toast**	**Prune Juice Hot Cereal 3-Minute Egg Toast**	**Orange Juice Hot Cereal Scrambled Eggs Toast**	**Peach Nectar Hot Cereal 3-Minute Egg Toast**	**Apricot Nectar Hot Cereal Bacon Curls Toast**	**Grapefruit Juice Hot Cereal Baked Egg Toast**	**Apple Juice Hot Cereal Omelet Toast**
	P	Tomato Juice Hot Cereal Poached Egg Toast	Honey Dew Melon Cold Cereal Crisp Bacon Sweet Rolls	Prunicot Cold Cereal Shirred Egg Toast	Orange Tidbits Hot Cereal French Toast—Syrup	Peaches—Cream Cold Cereal 3-Minute Egg Toast	Cantaloupe Hot Cereal Bacon Curls Danish Coffee Ring	Grapefruit Half Hot Cereal Baked Egg Toast	**Stewed Apricots Cold Cereal Fried Egg Toast**
LUNCH . .	H	French Roast—Celery & Mushroom Sauce Franconia Potatoes Fruit Salad Ice Box Pudding	Grilled Ham Steak Mashed Potatoes Frozen Broccoli Marinated Cucumber Wheels Apple Snow Tart	Hot Spiced Tongue Stuffed Baked Potato Pear-Grated Cheese Salad Oatmeal Cookies	Cold Sliced Roast Beef Potato Cakes Green Bean & Celery Salad Iced Cup Cake	Potato Chowder Club Sandwich Lettuce Wedge—1000 Is. Dr. Plum Cobbler	Chili Cheese Bun Hash Brown Potatoes Peach Bloom Salad Devils Food Cake	Stuffed Deviled Eggs Kidney Bean Salad Blueberry Muffins—Jam Krisped Relishes Butterscotch Pear	Vegetable Soup Ham—Cornbread Shortcake Cinnamon Apple Ring Salad Pineapple Chiffon Tart
	S	**Strained Soup Cottage Cheese Bean Puree Iced Graham Crackers**	**Strained Soup Baked Chicken Mashed Potatoes Bu. Peas Pitted Royal Anne Cherries**	**Strained Soup Stuffed Baked Potato Spinach Puree Baked Custard**	**Strained Soup Cottage Cheese Beet Puree Ice Cream**	**Strained Soup Sliced Chicken Creamy Rice Cabinet Pudding**	**Strained Soup Creamed Salmon Bu. Peas Canned Peach**	**Strained Soup Stuffed Deviled Eggs Baked Potato Butterscotch Pear**	**Strained Soup Cottage Cheese Bean Puree Cherry Custard**
	P	French Roast—Celery & Mushroom Sauce Franconia Potatoes Fruit Salad Ice Box Pudding	Grilled Ham Steak Mashed Potatoes Frozen Broccoli Marinated Cucumber Wheels Apple Snow Tart	Hot Spiced Tongue Stuffed Baked Potato Pear-Grated Cheese Salad Oatmeal Cookies	Cold Sliced Roast Beef Potato Cakes Green Bean & Celery Salad Iced Cup Cake	Potato Chowder Club Sandwich Lettuce Wedge—1000 Is. Dr. Plum Cobbler	Chili Cheese Bun Hash Brown Potatoes Peach Bloom Salad Devils Food Cake	Stuffed Deviled Eggs Kidney Bean Salad Blueberry Muffins—Jam Krisped Relishes Butterscotch Pear	Vegetable Soup Ham—Cornbread Shortcake Cinnamon Apple Ring Salad Pineapple Chiffon Tart
DINNER . .	H	Broiled Lamb Chops Duchess Potatoes Garden Peas Wilted Spinach Salad Blueberry Pinwheel	Hot Shredded Chicken Open Sandwich Latticed Potatoes Krispy Relishes Assorted Fresh Fruits Chocolate Milk Shake	Chilled Fruit Juice Braised Beef with Noodles Stewed Okra Corn Relish Salad Cherry Roll	Lamb Pattie—Caper Sauce Bu. Lima Beans Broiled Tomato Half Mexican Salad Norwegian Prune Pudding	Roast Fresh Ham Whipped Potatoes Spinach a la Swiss Tossed Salad Greens Escalloped Apples	Veal Birds Watercress Potatoes Bu. Peas Stuffed Celery Salad Fruited Floating Island	Curry of Halibut Delmonico Potatoes Harvard Beets Wilted Spinach Salad Sponge Jelly Roll	Chicken a la Maryland Candied Sweet Potatoes Creamy Corn Chiffonade Salad Green Gage Ice Cream
	S	**Strained Soup Broiled Lamb Chop Duchess Potatoes Summer Squash Canned Pear**	**Strained Soup Stuffed Deviled Eggs Beet Puree Chocolate Milk Shake**	**Chilled Fruit Juice Beef Loaf Bu. Noodles Diced Carrots Vanilla Wafers**	**Strained Soup Broiled Lamb Pattie Riced Potatoes Bean Puree Norwegian Prune Pudding**	**Strained Soup Broiled Beef Pattie Whipped Potatoes Bu. Peas Apple Sauce**	**Strained Soup Broiled Veal Pattie Bu. Potatoes Summer Squash Floating Island**	**Strained Soup Baked Halibut Delmonico Potatoes Spinach Puree Sponge Jelly Roll**	**Strained Soup Chicken a la Maryland Riced Potatoes Sliced Carrots Chocolate Ice Cream**
	P	Breaded Veal Chop Duchess Potatoes Garden Peas Wilted Spinach Salad Blueberry Pinwheel	Hot Shredded Chicken Open Sandwich Latticed Potatoes Krispy Relishes Assorted Fresh Fruits Chocolate Milk Shake	Chilled Fruit Juice Braised Beef with Noodles Fried Okra Corn Relish Salad Cherry Roll	Lamb Pattie—Caper Sauce Bu. Lima Beans Broiled Tomato Half Mexican Salad Norwegian Prune Pudding	Roast Fresh Ham Whipped Potatoes Spinach a la Swiss Tossed Salad Greens Escalloped Apples	Veal Birds Watercress Potatoes Bu. Peas Stuffed Celery Salad Fruited Floating Island	Curry of Halibut Delmonico Potatoes Harvard Beets Wilted Spinach Salad Sponge Jelly Roll	Chicken a la Maryland Candied Sweet Potatoes Corn on Cob Chiffonade Salad Green Gage Ice Cream

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monthly menus hm . . . August 1952

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		Sun. Aug. 17	Mon. Aug. 18	Tues. Aug. 19	Wed. Aug. 20	Thurs. Aug. 21	Fri. Aug. 22	Sat. Aug. 23	Sun. Aug. 24
BREAKFAST . .	H	Casaba Melon Cold Cereal Link Sausage Orange Coffee Cake	Fresh Grapes Hot Cereal Poached Egg Toast	Blended Fruit Juice Hot Cereal 3-Minute Egg Toast	Fresh Plums Cold Cereal Crisp Bacon Cinnamon Bun	Grapefruit Juice Hot Cereal Omelet Toast	Berries—Cream Cold Cereal Scrambled Eggs Toast	Sliced Oranges Hot Cereal Baked Egg Raisin Toast	Pineapple Tidbits Hot Cereal Sausage Squares Kolaci
	S	Tangerine Juice Hot Cereal Crisp Bacon Toast	Grape Juice Hot Cereal Poached Egg Toast	Blended Fruit Juice Hot Cereal 3-Minute Egg Toast	Mashed Bananas in Orange Juice Hot Cereal Crisp Bacon Toast	Grapefruit Juice Hot Cereal Omelet Toast	Tomato Juice Hot Cereal Scrambled Eggs Toast	Orange Juice Hot Cereal Baked Egg Toast	Pineapple Juice Hot Cereal Crisp Bacon Toast
	P	Casaba Melon Cold Cereal Link Sausage Orange Coffee Cake	Fresh Grapes Hot Cereal Poached Egg Toast	Blended Fruit Juice Hot Cereal 3-Minute Egg Toast	Fresh Plums Cold Cereal Crisp Bacon Cinnamon Bun	Grapefruit Juice Hot Cereal Omelet Toast	Berries—Cream Cold Cereal Scrambled Eggs Toast	Sliced Oranges Hot Cereal Baked Egg Raisin Toast	Pineapple Tidbits Hot Cereal Sausage Squares Kolaci
LUNCH . .	H	Roast Prime Ribs of Beef au Jus Golden Brown Potatoes Cauliflower, Polonaise Pickled Baby Beet Salad Chocolate Fudge Pudding	Steak & Kidney Pie Succotash Tossed Green Salad Marble Cake	Tomato Consomme Hot Roast Pork Sandwich Julienne Vegetable Salad Green Apple Sauce	Swedish Meat Balls Pittsburgh Potatoes Asparagus-Egg Salad Peach Tart-Wh. Cr.	Cold Luncheon Meats Potato Salad Hot Biscuits—Jelly Assorted Fresh Fruits	Shrimp Curry Fluffy Rice Tomato—Green Bean Salad Cake Top Lemon Pie	Canadian Bacon Escalloped Corn Lettuce Wedge—Fr. Dr. Refrigerator Cheese Cake	Chilled Fruit Juice Chicken Pot Pie Bu. Green Lima Beans Olives—Radish Roses Peach Ice Cream
	S	Strained Soup Roast Chicken Mashed Potatoes Beet Puree Vanilla Ice Cream	Julienne Soup Spaghetti with strained Tomatoes Summer Squash Baked Custard	Strained Soup Creamed Chicken on Toast Points Diced Carrots Apple Sauce	Strained Soup Beef Loaf Bu. Asparagus Tips Canned Peach	Strained Soup Cottage Cheese Bu. Peas Gelatine Cubes—Custard Sauce	Strained Soup Creamy Rice Bean Puree Lemon Meringue Pudding	Strained Soup Macaroni au Gratin Bu. Asparagus Tips Spanish Cream	Chilled Fruit Juice Baked Chicken Whipped Potatoes Summer Squash Peach Ice Cream
	P	Roast Top Round of Beef Golden Brown Potatoes Cauliflower, Polonaise Pickled Baby Beet Salad Chocolate Fudge Pudding	Steak & Kidney Pie Succotash Tossed Green Salad Marble Cake	Tomato Consomme Hot Roast Pork Sandwich Julienne Vegetable Salad Green Apple Sauce	Swedish Meat Balls Pittsburgh Potatoes Asparagus-Egg Salad Peach Tart-Wh. Cr.	Cold Luncheon Meats Potato Salad Hot Biscuits—Jelly Assorted Fresh Fruits	Shrimp Curry Fluffy Rice Tomato—Green Bean Salad Cake Top Lemon Pie	Canadian Bacon Corn Fritters—Syrup Lettuce Wedge—Fr. Dr. Refrigerator Cheese Cake	Chilled Fruit Juice Chicken Pot Pie Bu. Green Lima Beans Olives—Radish Roses Peach Ice Cream
DINNER . .	H	French Onion Soup Chicken Salad Potato Flakes Tomato Garnish Chilled Fruit Cocktail Sugar Wafers	Cushion Roast of Lamb Parslied Bu. Potatoes Creole Celery A-B-C Salad Fruit au Gratin	Swiss Steak Mashed Potatoes Green Beans, Gascon Fiesta Salad Indian Pudding	Savory Veal Roast Baked Sweet Potato Frozen Broccoli Shredded Lettuce Strawberry Ice Cream	Chicken with Dumplings Bu. Noodles Julienne Carrots Sunburst Salad Chocolate Chip Cottage Pudding	Tenderloin of Trout—Tartar Sauce Escalloped Potatoes Fresh Spinach—Lemon Perfection Salad Fruit Jumbles	Pot Roast of Beef Maitre d'Hotel Potatoes Bu. Peas Cauliflowerer Salad Blueberry Cobbler	Frizzled Beef Mushroom Casserole O'Brien Potatoes Summer Garden Salad Brownies
	S	Chilled Fruit Juice Creamed Eggs on Toast Bu. Peas Pitted Royal Anne Cherries Sugar Wafers	Strained Soup Broiled Lamb Pattie Bu. Potatoes Spinach Puree Fruit au Gratin	Strained Soup Broiled Yearling Liver Mashed Potatoes Bean Puree Indian Pudding	Strained Soup Broiled Veal Pattie Baked Potato Beet Puree Ice Cream	Strained Soup Chicken with Dumplings Bu. Noodles Julienne Carrots Chocolate Pudding	Strained Soup Baked Salmon Escalloped Potatoes Spinach Puree Sherbet	Strained Soup Broiled Beef Pattie Duchess Potatoes Bu. Peas Canned Pear	Strained Soup Stuffed Baked Potato Bean Puree Vanilla Wafers
	P	French Onion Soup Chicken Salad Potato Flakes Tomato Garnish Chilled Fruit Cocktail Sugar Wafers	Cushion Roast of Lamb Parslied Bu. Potatoes Creole Celery A-B-C Salad Fruit au Gratin	Swiss Steak Mashed Potatoes Green Beans, Gascon Fiesta Salad Indian Pudding	Savory Veal Roast Baked Sweet Potato Frozen Broccoli Shredded Lettuce Strawberry Ice Cream	Chicken Fricassee Bu. Noodles Julienne Carrots Sunburst Salad Chocolate Chip Cottage Pudding	Tenderloin of Trout—Tartar Sauce Escalloped Potatoes Fresh Spinach—Lemon Perfection Salad Fruit Jumbles	Pot Roast of Beef Maitre d'Hotel Potatoes Bu. Peas Cauliflowerer Salad Blueberry Cobbler	Frizzled Beef & Mushroom Casserole O'Brien Potatoes Summer Garden Salad Brownies

monthly menus hm . . . August 1952

H = house (normal or general) diets
S = soft diets
P = personnel menus

		Mon. Aug. 25	Tues. Aug. 26	Wed. Aug. 27	Thurs. Aug. 28	Fri. Aug. 29	Sat. Aug. 30	Sun. Aug. 31
BREAKFAST . .	H	Cantaloupe Cold Cereal 3-Minute Egg Toast	Grapefruit Half Cold Cereal Shirred Egg Toast	Fruit Nectar Hot Cereal Poached Egg Toast	Blue Plums Cold Cereal Bacon Curls Muffins - Preserves	Bananas - Cream Cold Cereal Omelet Toast	Orange Juice Hot Cereal Scrambled Eggs Toast	Honey Dew Melon Cold Cereal Crisp Bacon Butterscotch Biscuits - Jam
	S	**Cherry Nectar Hot Cereal 3-Minute Egg Toast**	**Grapefruit Juice Hot Cereal Baked Egg Toast**	**Fruit Nectar Hot Cereal Poached Egg Toast**	**Prune Juice Hot Cereal Crisp Bacon Toast**	**Apple Juice Hot Cereal Omelet Toast**	**Orange Juice Hot Cereal Scrambled Eggs Toast**	**Grape Nectar Hot Cereal Crisp Bacon Toast**
	P	Cantaloupe Cold Cereal 3-Minute Egg Toast	Grapefruit Half Cold Cereal Shirred Egg Toast	Fruit Nectar Hot Cereal Fried Egg Toast	Blue Plums Cold Cereal Bacon Curls Muffins - Preserves	Bananas - Cream Cold Cereal Omelet Toast	Orange Juice Hot Cereal Scrambled Eggs Toast	Honey Dew Melon Cold Cereal Butterscotch Biscuits - Jam
LUNCH . .	H	Savory Meat Loaf Creamed Diced Potatoes Fruit Salad Cream Cheese, Crackers & Jelly	Grilled Bologna Stuffed Tomatoes with Macaroni & Cheese Tossed Salad Greens Iced Apricot Tart	Hamburger-Bun Lyonnaise Potatoes Pickles - Relishes Fruited Gelatine - Wh. Cr.	Chilled Pineapple Juice Veal Paprika with Noodles Sliced Tomatoes Molasses Crunch Ice Cream	Vegetable Soup Salmon Salad Sandwich Potato Chips Vegetable Jackstraws Raisin - Rice Pudding	Mock Chili Poppyseed Twists Endive - Tomato Salad Fruited Caramel Eclair	Ham Hawaiian Hominy Cakes Bu. Peas Cherry - Waldorf Salad Pistachio Ice Cream
	S	**Strained Soup Beef Loaf Creamed Diced Potatoes Iced Graham Crackers**	**Chilled Fruit Juice Cottage Cheese Beet Puree Apricot Whip**	**Strained Soup Stuffed Baked Potato Bu. Peas Bananas with Soft Custard**	**Chilled Pineapple Juice Noodles au Gratin Bean Puree Vanilla Ice Cream**	**Strained Soup Creamed Salmon on Toast Spinach Puree Rice Pudding**	**Strained Soup Escalloped Potatoes Bu. Peas Baked Custard**	**Strained Soup Broiled Tenderloin Steak Mashed Potatoes Summer Squash Pistachio Ice Cream**
	P	Savory Meat Loaf Creamed Diced Potatoes Fruit Salad Cream Cheese, Crackers, & Jelly	Grilled Bologna Stuffed Tomatoes with Macaroni & Cheese Tossed Salad Greens Iced Apricot Tart	Hamburger-Bun Lyonnaise Potatoes Pickles - Relishes Fruited Gelatine - Wh. Cr.	Chilled Pineapple Juice Veal Paprika with Noodles Sliced Tomatoes Molasses Crunch Ice Cream	Vegetable Soup Salmon Salad Sandwich Potato Chips Vegetable Jackstraws Raisin - Rice Pudding	Chile Con Carne Poppyseed Twists Endive - Tomato Salad Fruited Caramel Eclair	Ham Hawaiian Hominy Cakes Bu. Peas Cherry - Waldorf Salad Pistachio Ice Cream
DINNER . .	H	Veal Cutlet Browned Potatoes Bu. Carrots Pickled Baby Beet Salad Boston Cream Pie	Fillet of Lamb Watercress Potatoes Pimiento Wax Beans Celery—Carrot Sticks Fresh Pear Cookies	Roast Loin of Pork Whipped Potatoes Acorn Squash Orange - Waldorf Salad Graham Cracker Roll	Chicken a la Maryland Chantilly Potatoes Bu. Carrots & Peas Normandy Salad Raspberry Macaroon Float	Golden Crusted Perch Rhode Island Potatoes Broiled Tomato Half Marinated Cucumbers Cake Top Lemon Pie	Cushion Roast of Veal Brabant Potatoes Bu. Asparagus Tips Avocado Relish Salad Fruit Compote	Vegetable Soup California Fruit Plate with Cottage Cheese Finger Sandwiches Prune Whip - Custard Sauce
	S	**Strained Soup Broiled Veal Pattie Riced Potatoes Bu. Carrots Fruited Gelatine—Wh. Cr.**	**Strained Soup Broiled Lamb Pattie Bu. Potatoes Bean Puree Canned Pear**	**Strained Soup Broiled Beef Pattie Whipped Potatoes Bu. Squash Sherbet**	**Strained Soup Chicken a la Maryland Chantilly Potatoes Bu. Carrots & Peas Brown Betty**	**Strained Soup Baked Whitefish Bu. Crumb Potatoes Beet Puree Lemon Snow Pudding**	**Strained Soup Broiled Veal Pattie Riced Potatoes Bu. Asparagus Tips Fruit Compote**	**Strained Soup Cottage Cheese Bean Puree Prune Whip - Custard Sauce**
	P	Veal Cutlet Browned Potatoes Bu. Carrots Pickled Baby Beet Salad Boston Cream Pie	Fillet of Lamb Watercress Potatoes Pimiento Wax Beans Celery—Carrot Sticks Fresh Pear Cookies	Roast Loin of Pork Whipped Potatoes Acorn Squash Orange - Waldorf Salad Graham Cracker Roll	Chicken a la Maryland Chantilly Potatoes Bu. Carrots & Peas Normandy Salad Raspberry Macaroon Float	Golden Crusted Perch Rhode Island Potatoes Broiled Tomato Half Marinated Cucumbers Cake Top Lemon Pie	Cushion Roast of Veal Brabant Potatoes Bu. Asparagus Tips Avocado Relish Salad Fruit Compote	Vegetable Soup California Fruit Plate with Cottage Cheese Finger Sandwiches Prune Whip - Custard Sauce

WHEN DIETARY SUPPLEMENTATION IS NEEDED... what more could a supplement provide?

If the concept of an ideal dietary supplement could be formulated, it might well be one that provides qualitatively every substance of moment in human nutrition. It would provide those for which human daily needs are established as well as others which are considered of value, though their roles and quantitative requirements remain unknown.

How Ovaltine in milk approaches this concept, and how well the recommended three glassfuls daily augment the nutritional intake, is shown in the appended table. The two forms of Ovaltine available—plain and chocolate flavored—are closely alike in their nutrient values.

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Three Servings of Ovaltine in Milk Recommended for Daily Use Provide the Following Amounts of Nutrients

(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

MINERALS		VITAMINS	
*CALCIUM	1.12 Gm.	*ASCORBIC ACID	37 mg.
CHLORINE	900 mg.	BIOTIN	0.03 mg.
COBALT	0.006 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.7 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U.
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 Gm.
*FAT	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

continued from page 98

food expenditures, labor payroll, laundry, repair and replacement of equipment . . no more. After all, the Woman's Building had been built in 1900 and from that date until 1924 had housed the home economics class rooms as well as the dean of women and currently 175 girls. There was no interest to pay, no bonds to amortize, no rental charges to meet, and no reserves for equipment to be allocated. I set up a purchase journal and turned in a monthly profit and loss statement. Beyond that no one bothered me at all.

Cost awareness . . By 1952 the casual food service operation of the depression years was a thing of the dim and forgotten past. The change from cost complacency to cost awareness was a gradual one and had its inception in those depression years. Michigan State College built its first dormitory financed on a self-liquidating basis in 1931 . . Mary Mayo Residence Hall for women.

The building was constructed and furnished through the issuance of dormitory certificates with a 6 per cent interest rate. In 1936 the outstanding Mary Mayo Dormitory 6 per cent certificates were refinanced by the issuance of a series of Michigan State Dormitory revenue bonds based on an interest rate of 3½ per cent. At this time, $750,000 was borrowed. It is interesting to note that of the total funds borrowed, $385,000 was the amount required to build Sarah Williams Residence Hall with a capacity of 266 at an average cost per student of $1,450. Contrast these figures with what it costs today . . roughly $5,000 per student with a much less expensive type of construction.

Since the date of the initial refinancing of the Mary Mayo Dormitory certificates in 1936, the University of Michigan, Michigan State College, the four Michigan Teachers' colleges, and the College of Mines in the Upper Peninsula have completed self-liquidating projects totaling more than 50 million dollars, projects built without direct expense to the taxpaying public.

Formula . . Now what is the formula for retirement for a self-liquidating bond issue? In determining the length of maturity it is important to remember that the longer the maturity, the higher the interest rate. Where high building costs and the inadequacy of other funds to supplement the revenue bond issue exist, the maturity may have to be extended over as long a period as the investment market will permit. This is usually considered not to be over 30 years. The average length of maturity is 20 years.

In addition to length of maturity, the choice between serial and term maturities is sometimes important. In serial maturities a fixed amount of principal is due each year and must be earned that year. With a term maturity, only the interest has to be paid regularly and more latitude is given in case of "off" years when earnings do not measure up to expectations. Revenue bonds to finance self-liquidating projects are frequently issued with a combination of serial and term maturities.

For an illustration of debt retirement for a self-liquidating project let's assume that we have a $1,000,000 loan; the available earnings to support that loan . . estimated on a conservative basis . . might be $70,000 a year. The fixed payments for interest and principle should not exceed 75-80 per cent of the $70,000. To illustrate the point: if it were $70,000 estimated earnings on a conservative basis (that is where you have to be careful) it is easy to put down figures to show you are going to earn $100,000 and then not be able to meet it. So in the first instance you do have to be conservative in that estimate. About 75-80 per cent of the estimated earnings would be used as a fixed payment to meet principal and interest and would be a level payment each year.

Now it is these level payments based on estimated earnings to meet principal and interest that are the concern of all the residence hall managers and food service directors at Michigan State College. The complete revenue-producing organization under the direction of Mr. Emery Foster includes, in addition to the residence hall accommodations for 6,500 students, the Union Building, the Kellogg Center for Continuing Education, the Food Stores, and the concessions.

Each type of operation presents its own management problems. Each manager is concerned with his own program of cost reduction on an operating core that has been pared and repared.

Three points . . However many facets there are to tap on a cost control system, the essential requisites may be summed up briefly in three points.

1. The system must be practical . . that is, it must not interfere with the working routine.

2. The system must give sufficient detailed information on which to base corrective measures. A good system will give summary figures on which to base action. Business pays off in action, not in figures.

3. The cost of the system must be considerably less than the saving effects. Since the major purpose of most business enterprises is to make a profit, any system of accounting or control which does not contribute materially to this profit by reducing costs and minimizing waste should be thrown out. And do not forget that people do not want to eat efficiency. They want good food. Don't drive them away with too much efficiency.

I repeat, no one cost control program fits the entire Department of Dormitories and Food Services at Michigan State . . aptly termed the B. and G. Department by Mr. Proulx, head of our Hotel Administration School. On further questioning Mr. Proulx said, "B. and G., oh, yes, I always forget that long complicated name and so I just put down the first thing that comes to my mind, Beds and Groceries, the B. and G. Department."

Systems . . A quick survey of the cost control systems at Michigan State College illustrates the fact that each operation must analyze its own situation. There is no one easy road to a 40 per cent food cost.

The Union Building Food Service shows a system based on a production planning chart and daily food cost analysis that is an adaptation of the standard precost precontrol procedures. Stated in the simplest terms the procedures provide ad-

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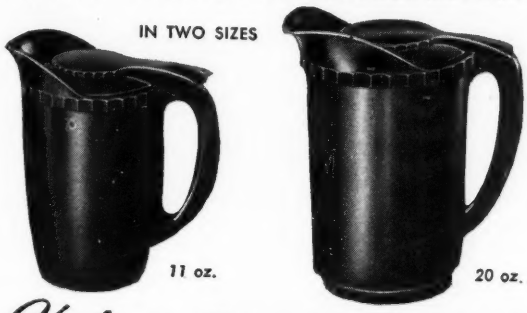

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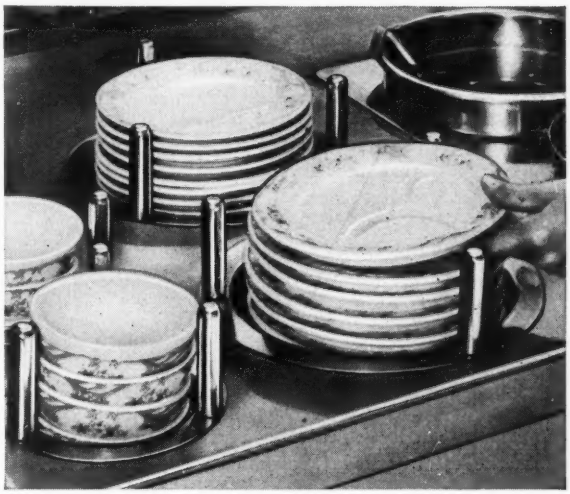

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Says dietician, *"Bacteria count remarkably reduced, thanks to enclosed storage and less handling. And for quicker service, these dispensers give us a good supply of dishes where we want them, when we want them."*

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vance information as to how much to buy of what and when, and how much to prepare of what and when. The main hinge of the cost control systems in use at the Union is hung on the premise that a minimum inventory precludes over-production and consequent waste. Walk-in refrigerator space, sharp space, and storage space for staple groceries and canned goods were computed on a fine margin. So fine was the margin, in fact, that the Food Stores services that unit twice each day if necessary. The secret of smooth operation in the Union Food Service lies in daily precision ordering from the Food Stores for the daily food production load.

The food service in the Kellogg Center points up the value of analyzing your own situation. The State Room and conference catering business are intermeshed to produce a feast or a famine of customers at the present. Another year's operation should level off the conference bookings to a better advantage for the food service manager.

For the State Room, which is a service dining room, the important factor in control is to get a running picture of the operation by a continuous analysis of the established menu pattern. The sales analysis can be tabulated for a breakdown of the entrees and serves as a basis for the orders as well as pointing up the seasonal shift in popularity of menu items. Before the serving period each kitchen menu is marked for portion size. This is a guide for the serving personnel on the range and service bar. The accounting department in Kellogg Center furnishes the food service manager with a daily Food Cost Report similar to the one at the Union.

Residence halls . . Now let's take a look at the residence hall organization. The women's residence halls have a census of 2,500 girls living in seven separate units. Each residence hall manager is responsible not only for the food service but also the housekeeping and social direction of the girls in her building. The primary management objective of Miss Mildred Jones, who is the director of the women's residence halls, is to coordinate the operational policies of these units. This is largely accomplished by the weekly menu meetings.

The problem of cost control is attacked in a manner slightly different from the daily food cost . . sales analysis system used in the Union and Kellogg Center. A weekly food cost report which gives a breakdown of income, food and labor expenses, house count and meals served is computed by each building manager's office. This serves as the basis for keeping the food and labor costs for each unit in line.

If any unit is running a consistently higher food percentage than the others a breakdown of the food purchases may point up that the control of dipping ice cream is lax, that the dinner meat orders are too heavy with the consequent use of expensive leftover roasts in luncheon dishes, that an extra allowance of milk has slipped into the picture, or that the baker is not using as much dried milk in baking as is specified.

For the purpose of cost control Miss Jones analyzes food expenditures in categories over a term period and compares the amounts served in the units. Portions are checked on the basis of ounces per capita to the average. Individual items of expenditure are scrutinized at the menu meetings.

This past week crackers were in the limelight. During the winter term the per capita cracker cost showed a range of 10 to 50 cents in the seven units. You all know what happened to the crackers in the 50 cent unit. But stabilizing cracker expenditures at ten cents per person per term would mean a saving of $1,000 for the year.

Miss Jones' philosophy of cost control is to impress on her resident managers the importance of little things, the fact that a half cent, a cent, or two cents per portion saved does not appear gigantic, but multiplied by 2,500 in the course of a year's operation the story is well worth considering.

Food stores . . In the general cost control pattern the College Food Stores are a vital factor. One of the reasons that central purchasing has proved to be satisfactory on our campus is the fact that the purchasing agent says that since he was the only boy in a family of seven girls, he learned early in life how to get along with women. In fact, he assures us that he prefers working with women in his business because they will do the careful and detailed work necessary for placing accurate orders.

For all practical purposes a college food store operates as a big wholesale grocery. The customers are supplied on a basis of scheduled deliveries with meats, perishables, canned goods and staple groceries. At this time I am going to mention two of the control procedures in use in the meat department.

For cost control the meat department runs basic tests on fabrication. These tests determine the pricing of items on the meat price list issued bi-monthly to the campus units. One of the tests recently completed which may be of interest to you pointed up the cost differential between the use of commercial fore quarters and carcass canner grade for ground beef. And ground beef, as you know, is a staple menu item for the college age boy and girl.

The data were compiled during normal operations of the meat department in March of this year. The findings were based on commercial grade fore quarters of beef from 600 pound cattle at an average market value of $.45 per pound, and on canner carcass beef 500-600 pound average at a market value of $.42 per pound. The average cost per pound of the boneless forequarter was .5723, that of the boneless carcass .5360. On 120,000 pounds of boneless beef . . which is the normal annual demand for this item . . the cost differential is $5,3620.90.

Further, the use of the leaner carcass cattle is advantageous in this particular situation because of the tremendous amounts of beef trimmings accumulated from choice and commercial grade rounds used for Swiss steak, cube steak, and roasts. The leaner carcass meat can absorb these fatter trimmings without a great deal of time and labor being spent for separating the fat from the lean to gain suitable ground products.

Test kitchen . . To serve as the coordinating link between the Food Stores and the Food Service opera-

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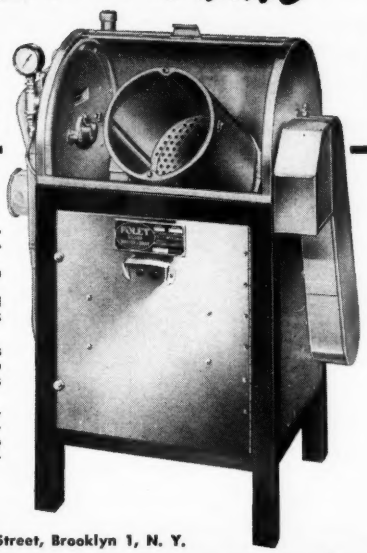

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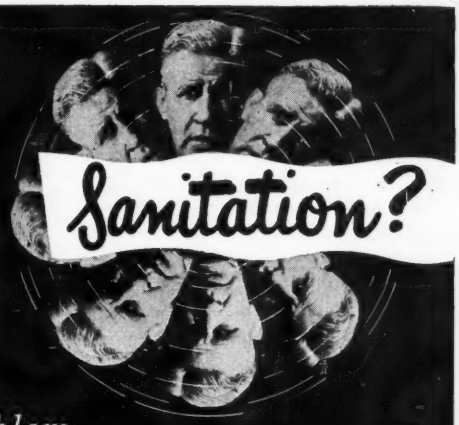

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tions on the campus, to point up specific operational leaks, and to work with the food service managers on recipe standardization and portion control we have a test kitchen, located in one of the residence halls and under the direction of Dr. Pearl Jackson Aldrich. Dr. Aldrich has a background of hospital food service, residence hall management, and this past year completed her doctorate in experimental foods under Miss Lowe of Iowa State College. Her appointment is jointly with the Department of Dormitories and Food Services as director of the Test Kitchen and with the Agricultural Experiment Station in a research capacity.

The test kitchen program, in operation less than a year, has served to indicate fertile avenues of savings. A series of meat studies in the residence halls has shown average cost variations at a given meal that might well plague management:

Entree	*Cost Range of Aver. Portion Served*
Roast Beef	.225 - .301
Roast Pork	.206 - .267
Roast Veal	.151 - .214
Baked Ham	.188 - .229
Roast Turkey	.281 - .364

These figures are provocative. The solution to the excessive cost range will mean extra revenue.

Dried Milk Solids . . One of the areas on which Dr. Aldrich has concentrated time and energy the past six months has been the utilization of dried milk solids in quantity food preparation. She has calculated that the substitution of dried milk solids for fluid milk on the range and in the bakeshop of the residence halls on the campus would mean an annual saving of $16,000.

The use of dried milk solids and water in recipes which require large amounts of milk has been shown to offer many advantages over the use of fluid milk. Among the most important advantages are:

1. Economy in actual food cost.
2. Freedom from refrigeration and storage problems.
3. Constant milk supply.
4. Reduction in handling much heavy weight food by service workers.

Since the available information on the substitution of dried milk for fluid milk in quantity food preparation is very limited, Dr. Aldrich is currently working on an experiment station project to determine proportions and practical techniques for substituting dried milk solids for fluid milk in quantity food preparation. To date the test kitchen program has substantiated a few facts. It has shown the momentary savings through the use of dried milk solids in milk based puddings averages 25 per cent. In other menu items, notably baking powder biscuits, muffins, and escalloped potatoes, the cost saving was found to be small but a great improvement in quality and easier manipulation resulted. The dried milk solids were increased 2½ - 3 times the amount required for reconstitution on the basis of solids in whole milk.

The test kitchen program on our campus is in its infancy, but with careful long range planning it should prove to be an indispensable factor in the total cost control program.

In working with our employes and making them cost conscious we have borrowed a few techniques from Miss Gladys Knight of our Tourist and Resort Service. Miss Knight has done an outstanding job in alerting the small restaurant and resort operator to the problems of management and cost control.

How do YOUR dietary costs compare with those on page ten ?

Visual aids are particularly well adapted to driving home a few points with this particular group. In some form or another you are undoubtedly familiar with most of these charts.

In conclusion I would like to re-emphasize the fact that there is no simple panacea for cost control. Each operator can collect ideas from industry, from other food service operators, from the reports of actual case histories in cost analysis. But in the end he is faced with the fact that he must analyze his own operation and figure out his own salvation. ■

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Cites public relations value of dietitian

■ THE DIETITIAN in a small hospital is a "public relations officer of great capacity," said Sister Mary Ethel, R.S.M., Our Lady of Mercy Hospital, Cincinnati, O., at a May 29 sectional meeting of the Catholic Hospital Association at Cleveland, Ohio.

Not only is a dietitian highly trained but, Sister Mary Ethel pointed out, she can be an able assistant to the administrator. She can help balance the budget by careful buying.

How do YOUR food costs compare with those on page ten ?

"To the medical staff her duties are many," she declared. "At staff meetings a well planned, appetitizing, inexpensive luncheon is a drawing card for a perfect attendance. . . A dietitian who serves attractive, well balanced diets and keeps the patients happy and content will win a place in the heart of every medical staff member."

She urged that the dietitian try to visit each patient at least once a day at tray time.

The dietitian should be a leader and guide to employes rather than a taskmaster, she said.

Miss Clara Jacobsmeyer of St. John's Hospital, St. Louis, said that proper organization for better service provides "that elasticity of service that is able to meet unforeseen situations as calmly as it takes care of the daily routine."

She warned against "wholesale upsetting of existing conditions" and if changes are contemplated she suggested beginning with evaluation of the present set-up, understanding why things are done as they are done, deciding what improvements should be made, discussing proposed improvements with the heads of related departments and taking time to explain the new plan to all concerned with it working.

The central tray service plan was described. She urged constant attention to details, from the attractiveness of the tray setting to the individual items placed on it. The style of coffee pot, she pointed out, may mean much in assuring the patient food satisfaction as she described the delight of a patient who found his coffee served in a thermos pot after he had carefully specified "hot" on his selective breakfast menu. ■

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hm

accounting and recordkeeping

Effective leadership

by Frederick C. Morgan, Comptroller • Genesee Hospital • Rochester, New York

Why is one person a more successful business-office manager than another? Is it because of technical knowledge or "know-how" of his job? Perhaps the "people" being more enthusiastic, happier, and more effective produce more than others. . .

■ A BUSINESS-OFFICE MANAGER has two clearly different but inter-dependent tasks:

1. To direct, supervise and *lead* the individuals under his authority.

2. To achieve the group objective (proper care and custody of hospital funds; efficient control and accounting of Receivables and Payables; periodic financial and statistical reports for the administrator's guidance; courteous and prompt attention to the requirements of public and employe relations; and constant recognition of the business office as a centralized unit for all departments of the hospital).*

The business manager who constantly sees to it that his people are taken care of, has to provide only a minimum of direction for his group in order to have a smooth-working and effective "team." His concern for their welfare will give him an intimate knowledge of the business problems involved and consequently make his work that much easier. *By taking care of his people and through their increased efficiency, his own success is assured.*

Very often, business-office managers are selected because of seniority. This in itself is hardly a sufficient qualification or assurance of management effort that builds a winning "team" . . with the business manager as a member of that team, though still its captain.

Teamwork requires each member's acceptance of his position and responsibility as an integral part of the combined effort and success of the group as a whole. The business manager as captain of the team should always refer to the responsible people of his team by name, when discussing the success of his group. By the same token, when a failure occurs, he should be just as quick to include his own name with that of the responsible member of the team.

Am I the right kind of supervisor? . . might be the important question we could logically ask ourself after careful analysis of the above fundamentals of executive philosophy. If positions were reversed, do you think you would be satisfied with the kind of supervision you are giving your people? I am quite sure you realize you should be giving your people the supervision and leadership that makes them like their jobs and treating them the way you would like to be treated if you were "in *their* shoes."

Frequently a supervisor forgets how he (or she) felt when under supervision himself. If supervisors would keep this in mind, many problems of job dissatisfaction would never occur. After considering for a moment the kind of supervision people want, ask yourself:

1. Do I show a personal interest in helping my people to get ahead?

2. Do I have a clear-cut understanding with each of my people as to their individual opportunities for advancement?

3. Do I give my people reason for confidence in my own impartiality and fairness?

4. Do I plan the work so that the people know what is ahead of them?

5. Do I set a fair task and not expect unreasonable results?

A sound executive philosophy . . will be found in all organizations where effective leadership predominates. The attributes and qualities (good or bad) of all top execu-

continued on page 118

*All too often, due to lack of training or understanding, the importance of the first of the above tasks is overlooked and attention given only to the second. Realization of this fact and the need for the correction of such an attitude are the reasons for this paper.

Cost breakdowns have to be analyzed sometimes, too

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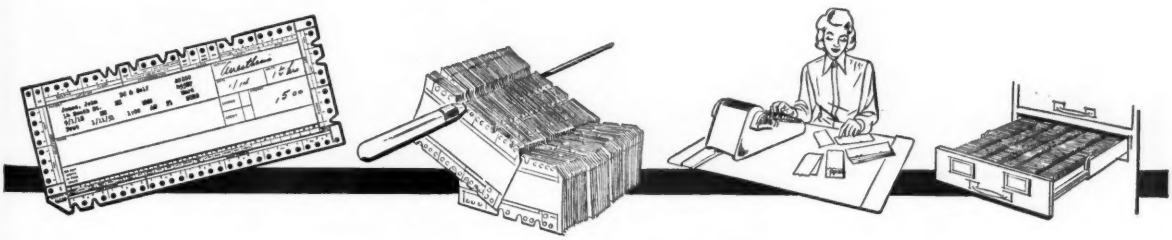

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Hospital laboratory fees: a national 'hm' survey

by
F. James Doyle
How's Business editor

■ HEREWITH ARE PRESENTED the results of the first in a series of surveys to determine charge structures in the nation's hospitals. The survey was developed as the "question of the month" which backs up the form on which hospitals send in data for the How's Business department conducted by this magazine with the cooperation of the American Association of Hospital Accountants. About 175 hospitals are represented in returns tabulated here for these special questions.

Form . . The questions concerned laboratory fees, and asked, "What does your hospital charge for the following?

Blood morphology tests?
CBC _____ _____
Blood chemistry tests?
N.P.N. _____ _____
UN _____ _____"
etc.

The replies were divided into the eight regions used in the How's Business section, and then subdivided into hospital-size according to number of beds. Averages were then obtained for each of the 24 sub-divisions, and these are shown here.

Any attempt at a detailed verbal analysis of these figures would be valueless, it is believed, since their message . . the variability of charges . . is obvious, and their purpose . . as a check-list for hospitals of a particular size in a particular area . . is equally patent.

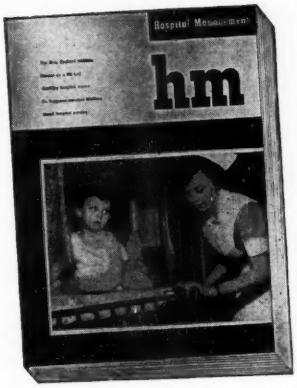
Warning . . One word more, however: It may seem elementary to point out again that these figures are *averages,* and must therefore not be misinterpreted. For example, a certain figure may not represent at all the *most frequent* charge in its category. For example, suppose the average charge for a test is $4.29 . . does this mean every hospital of that size in that area ought to

continued on page 118

New England			Region	Middle Atlantic		
1-100	101-225	225-up	Bed-size	1-100	101-225	225-up
$3.63	$5.00	$3.80	CBC	$4.00	$4.65	$4.31
2.63	3.00	3.40	NPN	4.38	2.96	3.12
2.67	3.50	3.00	UN	4.38	3.36	3.06
2.63	3.00	3.00	Sugar	4.38	2.75	2.56
3.25	4.00	3.60	Chol.	4.17	3.75	3.50
3.00	1.50	2.00	Van d. B.	4.38	2.98	3.31
3.00	1.00	3.00	Wass.	2.75	2.83	2.83
1.00	2.00	2.50	Kahn	3.00	2.60	2.25
—	1.00	2.00	Kline	3.00	2.08	2.42
—	1.00	3.00	Kolmer	3.00	2.65	3.20
2.33	1.50	2.00	Gon. Smear	3.00	2.08	3.67
—	6.00	—	Gon. sm. & cul.	—	4.75	—
1.50	1.50	1.40	Urin.	1.62	1.69	1.43
5.25	7.75	6.88	Tissue	7.00	5.13	6.19
25.00	10-25.00	—	Froz. tissue	—	—	—

South Atlantic			Region	South Central		
1-100	101-225	225-up	Bed-size	1-100	101-225	225-up
$3.33	$4.50	$5.25	CBC	$4.33	$4.08	$4.60
3.25	4.00	4.50	NPN	4.00	3.90	4.20
3.25	4.00	4.00	UN	5.00	4.13	3.50
3.00	3.25	3.50	Sugar	3.00	3.66	4.20
4.50	4.50	4.25	Chol.	4.67	5.92	5.60
4.25	3.73	3.50	Van d. B.	5.00	5.00	3.80
2.00	—	2.67	Wass.	2.75	3.70	4.00
2.00	1.00	2.25	Kahn	2.75	2.58	4.00
—	1.00	2.00	Kline	3.00	1.92	5.00
—	—	4.00	Kolmer	3.00	4.67	5.00
5.00	—	3.50	Gon. Smear	2.00	2.25	2.67
—	—	—	Gon. sm. & cul.	—	—	7.00
1.17	1.25	1.63	Urin.	1.50	2.17	3.30
6.50	8.00	5.75-15	Tissue	7.00	6.20	8.20
—	—	—	Froz. tissue	—	10.00	10.00

East North Central			Region	West North Central		
1-100	101-225	225-up	Bed-size	1-100	101-225	225-up
$4.00	$4.71	$5.00	CBC	$4.00	$4.75	$3.20
3.08	3.33	4.00	NPN	4.30	2.45	2.89
2.50	3.60	4.00	UN	3.25	2.65	4.39
2.70	3.50	3.50	Sugar	3.08	3.21	2.03
3.17	4.92	4.00	Chol.	4.33	3.67	3.26
2.75	3.58	2.50	Van d. B.	4.00	3.50	3.15
1.67	2.33	2.00	Wass.	2.00	2.67	3.01
1.75	2.60	2.25	Kahn	2.20	2.50	1.98
1.00	—	1.25	Kline	1.70	1.66	1.91
—	—	1.75	Kolmer	2.00	2.50	1.83
1.75	1.00	2.00	Gon. Smear	1.33	3.33	3.01
—	—	—	Gon. sm. & cul.	7.50	—	—
1.67	1.54	1.25	Urin.	1.33	1.37	1.50
5.40	6.33	5.00	Tissue	5.80	5.32	6.63
—	10.00	10.00	Froz. tissue	—	—	12.00



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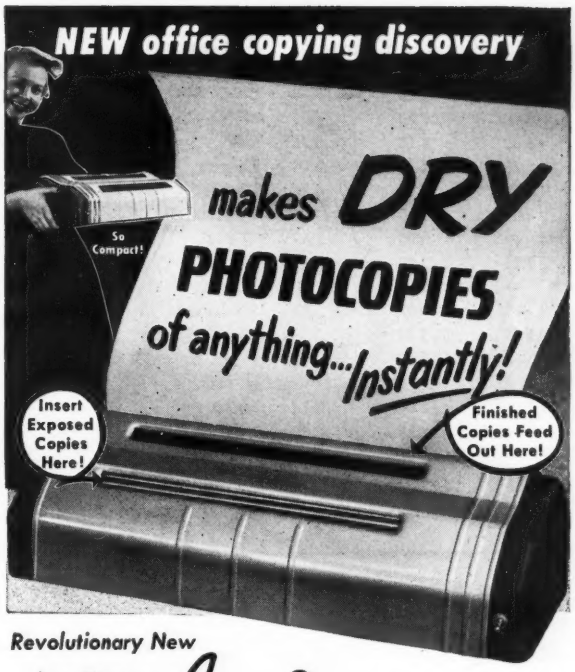
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5.00	5.00	4.63	NPN	5.25	4.59	4.25
5.00	4.19	5.75	UN	4.75	4.00	4.25
4.25	4.19	3.88	Sugar	4.00	4.09	3.25
5.00	5.31	4.75	Chol.	4.33	5.25	5.00
5.00	5.00	4.16	Van d. B.	4.50	4.50	4.00
—	5.00	2.67	Wass.	4.00	3.00	5.00
2.25	3.50	2.50	Kahn	4.00	3.09	2.50
—	5.00	2.50	Kline	3.00	3.25	—
—	5.00	2.75	Kolmer	3.67	3.50	4.00
2.00	2.50	2.50	Gon. Smear	4.00	2.50	2.50
—	5.00	—	Gon. sm. & cul.	—	—	5.00
2.00	2.00	1.63	Urin.	2.00	2.09	1.75
3.50-10	8.66	6.38	Tissue	10.00	7.60	10.00
—	to 25.00	13.33	Froz. tissue	—	15.00	—

be charging about that amount? Not at all . . the most common charge is really $5 (four out of seven respondents), but it so happens that the other hospitals responding charge $2.50, $3.50 and $4 . . which changes the over-all picture considerably.

Likewise, it was not thought desirable to arrive at national averages, since the tables' regional and bed-size break-down constitutes their merit in view of the detail of the questions. ■

The next in this series of articles will appear in the August issue of Hospital Management . . .

Effective leadership

continued from page 114

tives affect and color the organization they control sometimes in an unsatisfactory manner and to a degree not admitted by such business managers. It is human habit to watch and observe authority and then to emulate it, as well as to carry out management's wishes for definite reward. Good, efficient workers do not work long for poor business managers, and no organization can long survive the lack of some good workers. A poor system of organizational and operational procedure may detract from the efforts of a good manager, but a good system will hardly improve the performance of an inefficient staff.

A business manager must, as his first responsibility, recognize and accept the importance of his function to the hospital and realize the ultimate goal and purpose of the hospital in everything he thinks, says, or does. A sound executive philosophy is of great importance to the entire hospital. It must be thoroughly sound if the business manager is to get the best results from his department as well as for himself.

A fundamental and yet outstanding principle of *good* management is that responsibility and authority go hand in hand, and, where fairness exists, in equal quantity. No manager or supervisor should ever be held responsible for something over which he has little or no authority.

One of the prime requisites of a good business manager is the willingness to accept responsibility, i.e., to be prepared at all times to answer for the actions of each person in his group as well as himself. It is this philosophy of co-ordinated capabilities. Frequently, as a result of poor methods of selection, and/or failure to train business-office managers in their fundamental duties, a "so-called" manager attempts to serve in an executive capacity, with little or no knowledge of directing people, and with little understanding or appreciation of his position's importance.

There is no substitute for accomplishment. No man is really a "top executive" unless his people are truly working their best for him. He can then carry out other duties for and with his associates and superiors. People must not only like their supervisor; they must be truly inspired by him. It must be recognized, however, that "being well liked" does not necessarily signify a good business-office manager. Being liked is certainly a valuable quality, but it should not be the first objective of a supervisor in handling people. A good business-office manager must at all times demonstrate by his actions that he honestly believes his own interests are identical with those of each member in his group, and with those of the organization they all work for.

Successful leadership is the result of no particular secrets; the components are generally known. But the understanding of these components and the correct relationship of one to another are not always entirely understood. This has resulted today in there being many poor business managers in positions or authority. The top executive of any organization as well as the lowest ranking supervisor must direct their people with exactly the same results if they are to be outstandingly successful.

Every modern hospital requires foresight and a broad sense of perspective in its administrator. This type of leadership, which should radiate throughout the organization with genuine sincerity, will result in an enthusiastic, hardworking, competent group.

6. Do each of my people have the proper materials and equipment to enable them to produce the required results?

7. Do I show a constant interest in the safety and health of my people?

8. Do I give orders and instructions considerately?

9. Do I keep promises to my people?

10. Do I make people feel they are working "with me" rather than "under me"?

If you can answer "Yes" to these questions, then you are probably the right kind of supervisor . . the kind that people like.

Eight qualities determine supervision ability . . according to a survey of several leading organizations. These are listed, with commentary, below.

1. Ability to develop an organization . . a supervisor's value is proportionate to the usefulness of the group of people whose effort he directs. Ability to establish and maintain an effective organization which not only meets current needs but readily adapts itself to changing requirements, is a first essential for every supervisor.

2. Personal leadership . . in developing subordinates to maximum efficiency, enthusiasm and teamwork gives a "team" that *extra* punch which produces recognizable results.

3. Ability to plan work . . fiery enthusiasm in a "team" is ill-spent unless the supervisor has ability to analyze and schedule routine and emergency work with dispatch and efficiency, and with a long-range viewpoint.

4. Technical knowledge . . so that he will never have to apologize to his "team" or to management, a supervisor needs adequate knowledge for present work as well as his capacity to gain additional knowledge for new and more important work.

5. Cooperation in executing organizational policies . . a supervisor must understand, explain, and secure adherence to organizational policies and procedures. He should also suggest new procedures for making them more effective.

6. Judgment and decision . . to keep his team clicking smoothly, a supervisor must exercise sound judgment and make prompt, effective decisions.

7. Acceptance of responsibility . . a real supervisor or executive willingly assumes full responsibility for work supervised.

8. Constructive and independent thinking . . ability to originate and develop ideas intelligently and to make constructive suggestions and improvements is one of the most important factors in good supervision.

The second and concluding portion of Mr. Morgan's paper will appear in the August issue of Hospital Management.

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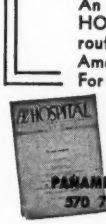

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Preservation of whole blood and red cells

by **Robert B. Pennell, Ph.D.** Assistant Director of Immunochemical Research • Sharp & Dohme, Incorporated

■ IN A MAJORITY OF INSTANCES where transfusion is needed, the agent of first choice is compatible whole blood. Even when whole blood is not the most desirable agent, resuspended erythrocytes are often indicated. The development of modern blood-banking technique, with its extensive understanding of blood typing, already has made both of these agents available in a manner not believed possible a few years ago. There remains, however, a single major obstacle to the fullest realization of the potentialities of these materials. The obstacle is the inability to maintain blood in a state suitable for transfusion for periods longer than about 21 days.

This is not for lack of effort to develop methods that will provide for prolonged blood storage. But, though evidence of small progress in this field will be presented, there are as yet no really satisfactory practical techniques for a major extension of the life of blood outside of the organism. So much effort has been spent on these studies in so many laboratories that it seems desirable at this time not only to report the present status of blood storage but also to re-examine the nature of the problem in the hope that such an examination may suggest the path to new research.

The problem . . Let us first define the problem. Blood is an extremely complex tissue which, like other tissues, exists in the body in a dynamic state. We know that it consists of three major types of cellular elements, erythrocytes, leukocytes and platelets and a fluid portion, plasma, in which some 35 proteins in solution have been identified. Now plasma is known to be useful for most transfusion purposes long after it has lost many of the properties characteristic of its native state.

Platelets and white cells, even when collected by the most careful methods, are probably destroyed soon after transfusion, but this destruction causes no major difficulty. These cellular elements, while vital in special instances, are not essential in most transfusions. In contrast, red cells provide the increased oxygen transport that is most often needed in transfusions and the rapid destruction of defunct red cells in the body causes severe clinical reactions. Thus, superficially at least, the problem of blood storage consists in keeping the predominant cellular element, the erythrocyte, in a state in which it can maintain its major function of oxygen transport.

It was stated, however, that blood exists in a dynamic state in which there are many interactions among the components. Our knowledge of these interactions insofar as erthrocytes are concerned is not yet extensive, but it is suggestive. It has been shown by Tullis that a nucleoprotein released by white cells will hasten the destruction of red cell membranes.

It has been shown in our laboratory that a protein from plasma will lend increased stability to the red cell membrane. The well-known interaction of isohemagglutinins with red cells has given rise to the extensive field of blood typing. It has been reported that tagged cholesterol introduced into the blood stream is rapidly taken up by the beta-1 lipoprotein of plasma and that this cholesterol exchanges rapidly with the cholesterol of the red cell membrane. An antisphering factor present in plasma helps preserve the biconcave discoidal shape of the erythrocyte.

I am suggesting that maintenance of erythrocytes in whole blood can only superficially be considered a problem to be solved by attention to the red cell alone. In the final analysis, it is unalterably interrelated with the maintenance of the other components of blood because of these, and probably of other yet unrecognized, natural interactions. It is perhaps for these reasons that the problem of storing red cells separated from other plasma components has appeared somewhat more amenable to manipulation than has the storage of whole blood.

Suitability for transfusion . . Even though we may not legitimately concern ourselves with erythrocytes alone, it is the state of the erythrocyte that ultimately defines the suitability of blood for transfusion. Laboratory data have so frequently been misleading in forecasting *in vivo* survival of red cells that there is a tendency, where possible, to dispense with such data in blood storage studies and to go directly to the clinic. The number of variables to be manipulated is so great, however, that it would appear

continued on page 126

This paper was read at a symposium on "Frontiers of Research on Blood and Plasma Extenders," marking the formal dedication of the new Sharp & Dohme Medical Research Laboratories, West Point, Pa., Monday, May 12, 1952.

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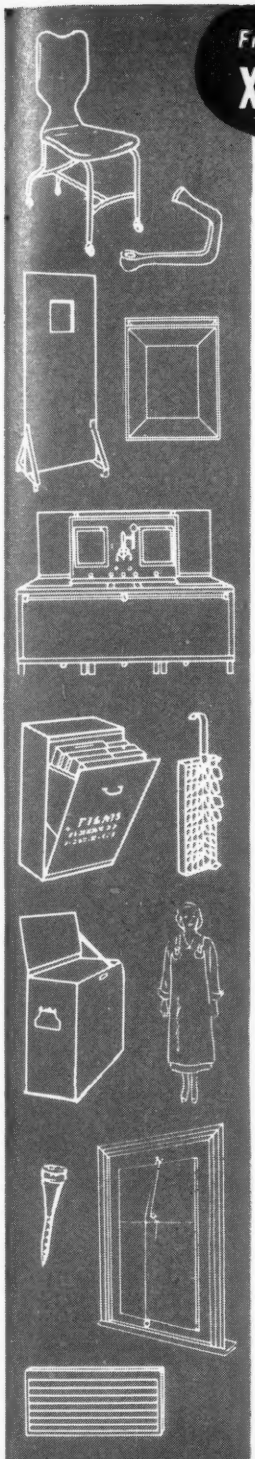

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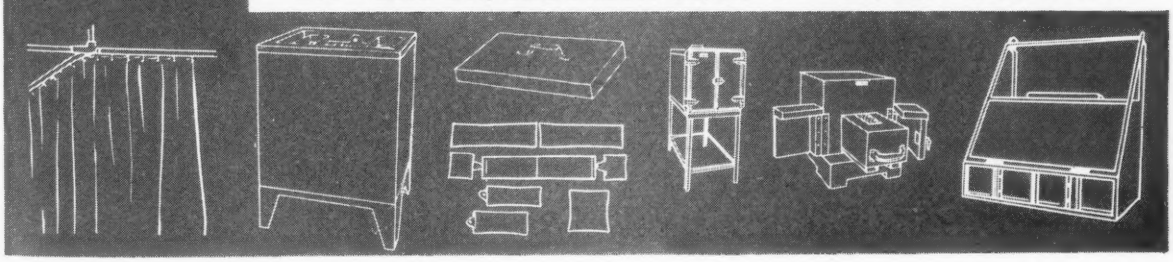

product news

hm literature

Mechanic's dream kit

■ THE GIANT HANDY ANDY, introduced by J. A. Sexauer Manufacturing Company, Inc., overcomes faucet repair troubles in a jiffy, restores worn-out faucets to better-than-new condition. This assortment of 1,079 parts comes in a sturdy metal case with a compartment for each item to provide easy selection of parts. Handy Andy is ready to give long, trouble-free service . . save time, water, fuel and labor.

Circle 701 on mailing card for details.

Safety finish for floors

■ THE MARS OF TRAFFIC on floors can be buffed out readily with Grip-Kote, a product of the Continental Car-Na-Var Corporation. Used like liquid wax, Grip-Kote is slip-proof and water-proof. It dries to a glossy finish in 25 minutes, may be buffed for still higher gloss. Grip-Kote is adapted for all types of floors (linoleum, rubber, varnished surfaces, etc.) and is especially recommended for mopping asphalt floors.

Circle 702 on mailing card for details.

Nurse's "capping" lamp

■ A MINIATURE ALADDIN'S LAMP makes a unique and treasured remembrance of the capping ceremony. Handsome in appearance, the lamp is triple silver plated and lacquered with antimony lead base. Weighing 10 ounces, it is 4¾ x 2-1/7 x 3", with a small, graceful candle fitted into the pointed tip. This lamp is available only through the American Hospital Supply Corporation.

Circle 703 on mailing card for details.

"Get well" with music cards

■ HOSPITALS equipped with Dahlberg Hospital Pillow Radio Service now offer visitors a chance to give patients a combination "get well" card and gift. Cards are designed for new mothers, women and men patients, and visitors may insert up to 10 dimes on the inside of the attractively illustrated card. Each dime allows patient a full hour of radio playing time.

Circle 704 on mailing card for details.

Two-way bandage dispenser

■ BAUER & BLACK is now making a new 100-bandage package of Curad plastic bandages. Extra convenience is offered in the 2-way dispensing box, designed to make dispensing easy . . from a drawer, or package when hung on the wall. Made of skin-thin elastic plastic, Curads are waterproof, oil resistant, won't curl or fray . . especially developed for doctors and hospitals.

Circle 705 on mailing card for details.

Good food on the move

■ SEAMLESS, SANITARY construction is found in the All-Purpose, electrically heated, stainless steel food conveyor, a product of S. Blickman, Inc. Each unit provides top-deck insets, round wells for liquid foods, heated drawers and ample storage space. A one-piece, crevice-free construction permits cleaning by live steam and hot water. It's designed to handle all three feeding requirements in the hospital . . selective menus, ward service and special diets.

Circle 706 on mailing card for details.

Goodbye paint odors

■ A FULL LINE of odorless interior oil-base paints has been put on the market by the Keystone Paint and Varnish Corporation, including gloss, semi-gloss, flat, enamel, floor paint and varnish. Designed for every interior finish in a full selection of colors, the odorless paint can be applied while room is in use without disturbing patients or staff, and dries quickly. It should prove a boon to hospitals where obnoxious paint odors are disturbing to those who occupy or visit the premises.

Circle 707 on mailing card for details.

All-job floor machine

■ A NEW American floor maintenance machine is announced by the American Floor Surfacing Machine Co. Simplified design makes the new machine ideal for economical scrubbing, polishing, steel wooling, disc sanding and buffing all types of floors. It's recommended for wood, tile, asphalt, concrete, rubber, terrazzo or marble. Especially suited to jobs requiring portability ease and reduced weight. No special training necessary for easy, efficient operation.

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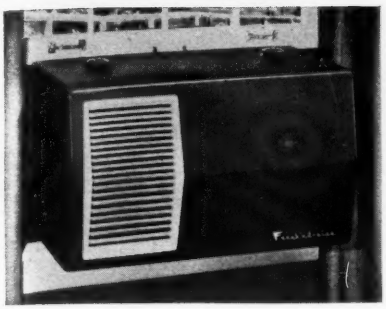
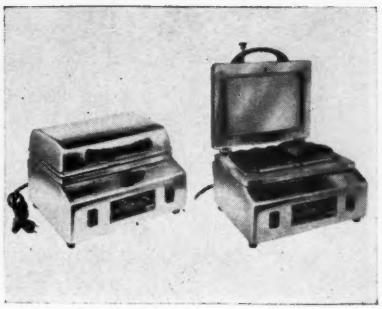


Electric summer breeze

■ FRESH'ND AIRE COMPANY has begun to turn out production models of the first of two electric air conditioning units which have been extensively field tested during recent months. The air conditioners come in half and three-quarter ton capacities, and are enclosed in heavy-gauge bonderized cabinets. Attractively finished in baked grey and green enamel, they offer an excellent way to keep patients' rooms cool, even in the hottest weather.

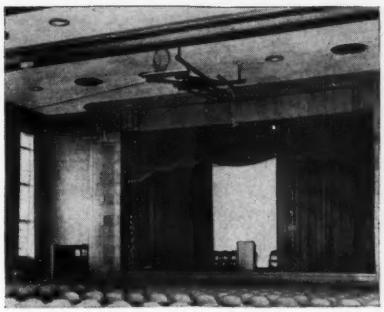
Circle 709 on mailing card for details.



Unique dry steamer

■ STEAM-ETT, a new high-speed dry steamer for buns and other baked goods, has been introduced by Republic Marketing Corporation. It heats baked goods thoroughly in just three seconds . . restores even 4-day old buns to an oven-fresh condition. Other advantages include elimination and expense of dried-out foods, no installation necessary, nothing to burn up or out, nothing to explode. This compact unit is safe and easy to use.

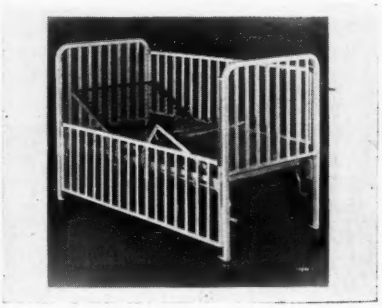
Circle 710 on mailing card for details.



Fire resistant fabrics

■ DURA-DECOR FABRICS lead the way for safety, appearance, time-saving upkeep and for a wide variety of uses as shown in the picture. Fabrics made of Fiberglass reinforcing cloth are woven of strong, pliable, inorganic glass threads. A special coating process, with synthetic plastic, makes Dura-Decor fabrics long lasting. They will not crack, peel or harden. Especially recommended for institutional use because of permanent fire resistant qualities.

Circle 711 on mailing card for details.



New beds for baby

■ A NEW IMPROVED, safer all-purpose crib has been introduced by Hard Manufacturing Company. The Hard crib has a convenient, low-spring-height of 25″ and is a full 77″ long. It assures complete safety . . even with the smallest of children. Made with extra narrow filler openings, no opening is over 3″ wide. The Hard crib is especially practical for the small hospital where equipment must many times serve several purposes. Sturdy construction features make this unit serviceable and assure long, trouble-free use.

Circle 712 on mailing card for details.

Sponge yarn keeps it clean

■ DU PONT SPONGE YARN is actually the familiar cellulose sponge, now done up in ¼″ rope form with reinforced cotton fibre core. Time and labor are saved because sponge yarn soaks up water . . resulting in fewer trips to the pail. Larger floor areas can be covered with less rinsing. Sponge yarn leaves no lint, will not scratch or tangle. Easy to clean, the yarn may be sterilized in boiling water without any loss of strength. The Du Pont sponge yarn mop is recommended for washing, damp mopping and water waxing all hospital floors.

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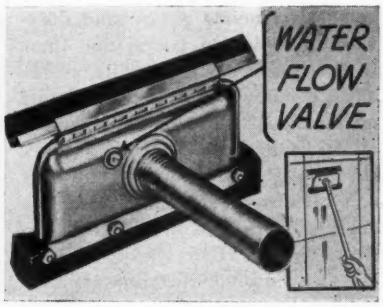
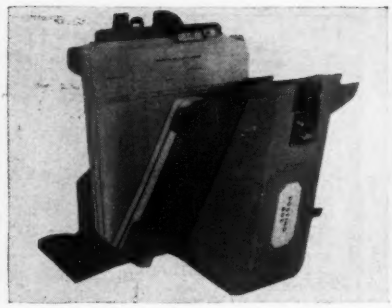


Window washing wonder

■ A NEW WINDOW WASHER entirely self-contained with washing wick, water supply and wipe-dry squeegee has been announced by Haldane-Blake, Inc. The washer is made of aluminum and eliminates buckets, brush, sponge, hose and ladder. Just a touch of the valve starts and stops the water flow fed from a self-contained water supply to the wool felt wick. The specially cured rubber squeegee dries and polishes quickly. With this new window washer, you can clean the dirtiest of windows with new speed, ease and freedom.

Circle 714 on mailing card for details.



Posting made easy

■ A DIFFERENT type of posting tray which offers maximum security while allowing the contents to be handled more easily, is introduced by Physician's Record Co. The light weight, easily portable tray holds 1,000 cards in easy reach, spaces at bottom save nipping, wide angle keeps sheets open for perfect visibility. Designed to save precious work hours, do a better job of posting in institutions.

Circle 715 on mailing card for details.

Cotton protection for hands

■ DANGER FROM BURNS is a thing of the past with the new heat-resistant, Tomac sterilizer glove. The thick cotton fabric, similar to terry cloth, is flexible and comfortable and provides excellent insulation. A 5″ gauntlet protects both wrist and forearm. Here is the same type glove worn by welders and factory workers requiring protection from heat. The glove is a product of the American Hospital Supply Corp.

Circle 716 on mailing card for details.

Disposable bed mat

■ A LOW COST, highly absorbent, absolutely waterproof protective paper mat that is disposable, is now being marketed under the name of "Lage Safe-Mat." Designed as a flexible, absorbent barrier between patient and mattress, it is odorless, does not rustle, absorbs perspiration and stays in place. It comes in rolls 36″ wide and 300 feet long . . or in sheet size for bassinet and standard size bed.

Circle 717 on mailing card for details.

New housekeeping help

■ COLGATE-PALMOLIVE-PEET COMPANY has announced a new synthetic detergent, Arctic Syntex HD. Colgate recommends it for hand dishwashing, cleaning floors, tile, linoleum, painted surfaces, walls, woodwork, windows and mirrors. Stable in hard water, an excellent foamer, mild in its action, Arctic Syntex HD is also recommended for rug and upholstery cleaning. Available packed 100 pounds in a fibre drum, Arctic Syntex HD is said to be ideal for any hospital cleanliness maintenance program.

Circle 718 on mailing card for details.

Radiation monitor at bed-side

■ PATIENTS RECEIVING X-RAY treatment can be assured that treatment is confined to diseased areas. Hospital personnel can be confident that they are not being exposed to excessive radiation while giving treatment. Developed by General Electric, the new radiation monitor, about the size of a quart fruit jar, is placed beside the patient. It indicates radiation present in an area at a given time. Doctors say the presence of the monitor relaxes patients and gives them confidence while undergoing treatment.

Circle 719 on mailing card for details.

Automatic defrosting freezer

■ INCORPORATING all features of Sta-Kold refrigerators, two new upright automatic defrost freezers are now in production. Added innovations are evident in the new Kramer Thermo-Banks, bakers racks and wire shelves. Automatic defrosting eliminates the inconvenience and time lost due to ice scraping. Available now, the 35 cubic foot two-door is a self-contained model. Also available is a 47 cubic foot, two-door, remote. Stainless steel heavy-duty freezer doors add to their beauty and long life.

Circle 720 on mailing card for details.

Small space dishwasher

■ FOR THE SMALL KITCHEN, fast food service operation, or separate unit in a large kitchen, the Universal roll top Model "D" is a compact, efficient dishwashing machine. It's full size, yet can be installed in just 2 square feet of floor space. This all-purpose dishwasher features revolving wash motion and rinse and adjustable 2 power operation which assure sparkling clean, thoroughly sanitized tableware, ready for quick re-use.

Circle 721 on mailing card for details.

Slippers offer safety

■ A NEW, ADJUSTABLE SLIPPER has been perfected by Melrose to give protection against static electricity sparks, and consequent explosions in operating rooms. Quickly slipped on over the regular shoe, the one-piece conductive rubber sole comes over the heel of the shoe and back inside where it fits so snugly it cannot be felt. Contact with the wearer is established through sock or stocking. Four sizes fit all doctors, nurses and visitors.

Circle 722 on mailing card for details.

New look in stove finish

■ A NEW SILICONE base finish, Granite-Gray, highlights the new Garland range, announced by Detroit-Michigan Stove Company. Other new Garland features include a shelf with built-in flue, one-piece stainless steel shelf plate and side panels with rounded edges, sturdy legs with adjustable height, heavy duty oven heat control. The new Granite-Gray finish and other features mean greater cleanliness and structural strength throughout.

Circle 723 on mailing card for details.

names & news of suppliers

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Dedication of new medical research laboratories

■ MORE THAN 1,000 distinguished scientists, doctors, business leaders and representatives of the press took part in dedicating the new $4,000,000 Sharp & Dohme Medical Research Laboratories (below) to the service of the medical and allied professions.

The magnificent four-story, L-shaped, brick and steel structure at West Point, Pa., contains about 110,000 square feet of floor space. The building, constructed in accordance with the most modern concepts of design, houses administration offices of the Research, Medical and Patent Divisions; a large conference room to accommodate up to 200 persons; a research library, and the scientific laboratories of the four sections of the Research Division.

The dedication of the new laboratories marks an important milestone in the history of the company. Just 22 years ago, Sharp & Dohme had only three full-time research scientists. Today, the company has a staff of over 200 men and women, employs approximately 3,700, who serve the medical and allied professions in all parts of the world.

After having the laboratory operations scattered among 11 different buildings at their Glenolden Plant, this new, larger building once again, in the words of John S. Zinsser, chairman of the board, "integrates our research facilities and is symbolic of our conviction that research is the foundation upon which the health and growth of the company depends. It is the building stone of our future."

Lakeside announces changes in scientific department

■ Dr. H. L. Daiell, vice-president and director of research, Lakeside Laboratories, Inc., Milwaukee, Wis., has recently announced changes within the scientific department. The pharmacy department will be known as the pharmaceutical department and will be headed by Harold C. Krahnke, formerly chief control chemist. The new analytical and control department will have Elmer Kluchesky as chief. Mr. Kluchesky has been promoted from the control department.

American Surgical Trade Association has Golden Jubilee

■ HALF A CENTURY of progress in providing hospitals, physicians and the public with surgical supplies and equipment essential to the nation's health was celebrated this past month at the four-day Golden Jubilee Convention of the American Surgical Trade Association.

Nearly 1,000 persons, from all parts of the U.S.A. and abroad, participated in the sessions at the Edgewater Beach Hotel in Chicago. Among them were designers, manufacturers, dealers and importers of surgical instruments and equipment.

Speakers for the Jubilee included Dr. Gunnar Gunderson, a director of the A.M.A.; Dr. Jack Masur, assistant surgeon general of the U.S. Public Health Service; Dr. Edgar C. Hayhow, director of the East Orange (N.J.) Hospital and past president of the A.C.H.A.; and Dr. B. W. Carey, director of Lederle Laboratories.

New contract division opened by Baumritter

■ The formation of a contract division to supply modern and maple furniture in complete lines for institutional, university and hotel use, has been announced by T. Baumritter Company, Inc. of New York City. Milton Gilbert heads this new division which will operate through regular contract and furniture dealers. A planning service will also be available, as well as manufacturing to specifications in orders large enough to warrant special production.

Other news . . Thomas A. B. Ferris has retired after 33 years with Parke, Davis & Co., Ltd. In recent years, he has been a salesman in Vancouver, British Columbia.

Fred J. Zahn, salesman for Abbott Laboratories, has been appointed to the promotional service division, as announced by H. S. Wilkinson, director of sales. Zahn's headquarters will be in the home office in North Chicago and his duties will include liaison work among the sales, research and medical departments.

Blood preservation

continued from page 120

to be absolutely essential to do preliminary laboratory studies for selection of those techniques most likely to justify clinical study.

Some of the confusion in the determination of the status of red cells during storage may have arisen from what appear to be two avenues of approach to the problem, nourishment of the cell and maintenance of structural integrity. Although their metabolic activity is atypical, mature mammalian erythrocytes nevertheless maintain an active glycolytic process and are equipped with an additional incompletely understood oxidative mechanism.

These mechanisms provide energy for the maintenance of hemoglobin in an active state and for the transport of substances into and out of the cell, and there is evidence that when these activities cease completely, the cell can never again be made useful. A continuing supply of dextrose, or other nutrient, is necessary to both mechanisms. In other words the cells must be fed during storage.

The erythrocyte contains a structural frame necessary, among other things, for the prevention of the escape of the tightly packed intracellular hemoglobin into the plasma. This structure is a selective permeable network of protein, lipide, and polysaccharide, several of its proteins being enzymes.

Current concepts suggest that transport through this structure to the interior of the cell is dependent on energy derived from the cell's metabolic processes and is accomplished by specific carriers, the carrier for potassium, e.g., being different from that for sodium. When this transport ceases the cell structure may disintegrate.

While maintenance of the metabolism of the cell and maintenance of its structure are actually inseparable processes they sometimes appear to be separable because the measurements used to determine structural integrity may give little information on the metabolic state of the cell, and the reverse is equally true.

Many studies of erythrocyte aging have employed only one type of measurement and have thus often yielded data of no meaning for the potential life of the cell after transfusion. To take extreme examples, application of fragility measurements to cells treated with formaldehyde or acrolein will indicate extreme stability of the structure of such cells.

The selective permeability of these cells is lost, however, and the pigment is converted entirely to an inactive and useless form. Again, certain types of blood collection provide erythrocytes of unusually high glycolytic activity, suggesting cells of unusual vitality, yet in the presence of this heightened activity the cell membrane is exceedingly fragile.

Divergent measurements . . We have attempted to circumvent some of these difficulties by using routine measurements touching divergent cell properties. Although it is not suggested that these will be found to be the techniques of ultimate choice, we presently employ osmotic fragility studies of cells previously equilibrated with plasma, the determination of cholinesterase, an enzyme located in or on the cell membrane, and Warburg manometric measurement of the anaerobic glycolytic potential of washed cells suspended in Krebs-Ringer solution. We often find these measurements yielding divergent indications of the state of the cells. Obviously, only studies in which the three types of measurement correlate can be considered to be hopeful.

The problem of feeding the cell during storage obviously can be abetted by slowing the rate of metabolism and reducing the demand for nutrient. This approach has been carried to the point of freezing the blood by several investigators. When one freezes, however, the structural portion of the cell may be disrupted by the transition to and from the crystalline state.

This problem has been met by Strumia by freezing at —3°C., by Sloviter by immersing the cell in glycerine prior to freezing, and by Luyet by vitrification. In all cooling, however, a problem is presented in that the integrated enzyme systems of metabolism are slowed at different rates, producing a slowly increasing imbalance in intermediate metabolites, and resulting in what Finch has recently called a biochemical lesion. This lesion is partially reversible *in vitro* by equilibration of the cells with fresh plasma and, up to a certain point, completely reversible *in vivo*. But accumulation of metabolites eventually produces a distortion of the cell followed by rupture, either *in vitro* or immediately after transfusion. Cooling and freezing also are known to be detrimental to the lipoproteins of plasma some of which seem to interact with the erythrocyte membrane. Cooling may in this fashion initiate a non-reversible pattern of deterioration.

Ionic balance . . Since most of the metabolic enzymes require a proper ionic balance for efficient operation, cell metabolism might be stopped by exchange of essential cations for sodium ions. Work with ion exchange agents has demonstrated either that this is not a tenable concept or that one cannot influence the interior of the cell sufficiently to be of value.

AEC must approve radioisotope work

■ IN ORDER FOR A HOSPITAL to have a radioisotope program it must obtain authorization from the Atomic Energy Commission, said Sister Ann Marie, R.S.M., St. John's Hospital, St. Louis, in a May 25 talk before the Institute of Medical Technologists of the Catholic Hospital Association at Cleveland, O.

The A.E.C. requires that each hospital have an isotope committee, she said, at least one member of which must have had previous experience in the clinical uses of radioisotopes, and a physicist either on the staff or as consultant to standardize sources, supervise handling techniques of the sources and to make certain that all personnel working with the activity are protected from excessive radiation.

She described some of the work being done at her hospital such as the uses of radioactive iodine in diagnosis and treatment of thyroid conditions. ■

A more successful attempt at this approach may be forthcoming from the work with chelating agents some of which may actually penetrate the erythrocyte membrane. One limitation to this approach may be the dependence of the cell membrane on some of the same cations removed. Cell physiology has shown the dependence of cellular membranes generally on the presence of calcium.

It might be presumed that the colloid osmotic pressure of the plasma proteins would offer important protection in the prevention of the distortion of the cell produced during storage. It can be shown in studies with resuspended cells, however, that certain plasma proteins, present in amounts affording colloid osmotic pressure equivalent to that of plasma, offer little protection beyond that provided by isotonic solutions of crystalloid.

Other proteins, such as modified globin or a plasma lipo-protein, offer protection completely without relation to their colloid osmotic effect, suggesting an interaction with the cell membrane as the factor determining the value of proteins in cell storage. Production of hypertonicity by the addition of sugars which will not penetrate the red cell has, however, been shown to exert a protective action during storage in the cold.

Fluid state . . The very first problem to be met in all blood storage, keeping the blood in a fluid state, may also influence the subsequent durability of the blood cells. Although careful attention to the use of non-wettable surfaces will permit the collection of blood that does not clot rapidly, for the purposes of storage one must resort to some form of anticoagulant. Usually this has meant use of an agent that will bind cationic calcium which is essential in coagulation.

At the moment citrate ion remains the agent of choice for this purpose, citrate being less toxic than oxalate and less expensive than heparin. Citrate, however, interacts with many plasma proteins, has an extremely toxic effect on white cells and produces some disturbance of the metabolism of erythrocytes.

It would seem desirable to avoid the use of any adulterating agent, if possible. An approach to this has been made in the use of ion-exchange resins which remove the cations rather than binding them. This has resulted in great improvement in the maintenance of the integrity of certain plasma proteins, and of leukocytes and platelets but, as mentioned above, has yielded little or no improvement in erythrocyte aging.

Another type of chemical binding agent, ethylene-diamine tetraacetic acid (Versene, Sequestrene) has been employed by Proescher as an anticoagulant and is being extensively studied at present with promise of improvement over citrate.

Two studies . . This brief statement of the problems to be handled in the storage of blood will furnish a background against which we may consider the accomplishment of the past few years in this field. Two studies have been published which suggest real possibility of the extension of the storage life of whole blood.

Smith, Sloviter and associates, following the observation that sperm can be preserved for extended periods by freezing in the presence of glycerine, have applied a similar technique to whole blood. Blood frozen rapidly at —79°C. in the presence of an equal quantity of 30 per cent glycerine has been held at this temperature for 42 days, then thawed and transfused with normal survival of those transfused cells which are not lost during the freezing and thawing. This demonstrates that by proper cooling one can sufficiently slow metabolic rates to produce a real extension of storage life. The present limitations of this technique are due to the loss of cells during thawing, which may be extensive in the longer storage periods, and to the difficulty of removing the glycerine before transfusion. This is presently being done by dialysis against graded concentrations of glycerine. Corroboration of this work has not yet appeared in the literature.

Strumia reported an extension of the life of whole blood and a still greater extension of the life of resuspended red cells. This was accomplished by collection of the blood in isotonic neutral citrate solution with careful admixing and refrigeration during the collection. Within 12 hours of collection, lactose, dextrose and citric acid were added to the whole blood, or lactose, dextrose and modified globin were added to red cells in a quantity equivalent to that of the plasma withdrawn.

Studies employing the techniques suggested by Strumia have been performed in our laboratory yielding data which appear to corroborate the improvement in aging suggested by him. Resuspension of cells in globin has been studied in at least two other laboratories, however, where lengthened survival *in vivo* has not been found. Careful examination of our data shows that each of the steps suggested are extremely important and that addition of globin may be meaningless unless each step is followed carefully. Both whole blood and re-

continued on page 139

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What's an executive housekeeper and what does she do?

by Flora B. Dooley Executive Housekeeper • John A. Archbold Memorial Hospital, Thomasville, Georgia

■ FIRST OF ALL, the hospital executive housekeeper is a business woman who has grown up with the times, keeping house away from home for millions of men, women and children who are sick. She is the active mind, the guiding hand in creating comfort throughout hospitals all over our land.

Little has been heard of the profession, for it is only in recent years that directors have seen the need of better educated women in the field, which, consequently, is not yet overcrowded. There are not enough competent housekeepers to supply the demand, although there are plenty of women who have had no training other than housework. These women are no longer in demand; their qualifications are insufficient.

The executive housekeeper must understand the fundamentals of business. She must have experience in meeting the public in order to serve them intelligently, or to have them served.

The ideal executive housekeeper should have good health, cheerfulness, a sense of humor, unselfishness, calmness and dignity. She must be courteous at all times to all people. She must be sincere and like people. Her most valuable asset is a knowledge of human nature, as she has to make many human contacts daily, properly appreciate the efforts of others and at all times cooperate loyally with her director.

Spirit of cleanliness . . The housekeeper's careful judgment should not only result in a clean hospital but also in competent employes. She must make each maid, janitor and porter feel that they are the keeper of that part of the hospital to which they have been assigned and that honest work, however menial, is something to be proud of.

The executive housekeeper should have a knowledge of cleaning materials, soaps, detergents, etc. She should thoroughly understand what equipment will give the best possible service with the least amount of labor. It is necessary to have a knowledge of textiles. She should be able to interview salesmen, to listen to what they have to offer and to select wisely the things needed in the department of housekeeping.

It is most essential that the executive housekeeper be allowed freedom of choice in the buying of materials and supplies with which to work. She, better than anyone else, knows the needs of her department, and she should, if necessary, fight for the right to choose her own equipment.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

More than 11,000 lives were lost in fires in the United States during the past year, the leading cause of which was carelessness in the use of matches and cigarette smoking.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

Things to do . . We have considered the qualifications for a good executive housekeeper. Let us now look at some of the things a good executive housekeeper should do. First of all, we must realize that housekeeping in a large institution is big business. The greater part of its cost is allocated to labor, and since labor is such a costly commodity, she must think about a training program for employes.

A training program in the housekeeping department should teach not only job procedures but use and care of equipment and teamwork among employes.

Employes are trained in order to make them better able to perform the duties for which they are paid. What the trainee learns depends in a large measure upon his or her instructor. The instructor must know housekeeping and also enjoy housekeeping in order to transmit ideas and skills effectively.

Select employes carefully, then give them the best possible training for the jobs they have to do. Emphasize the value of cooperation with other departments. Make the employe aware of his or her importance in relation to patient recovery and help them to feel that their contribution is as important in its way as is that of any other department in the hospital. Training hospital employes is part of the executive housekeeper's essential contribution to her hospital. ■

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"To protect the floors and simplify maintenance," would be a logical answer. However, these purposes can be served, and *still* the frequency of waxing can be reduced, by using *The Finnell Hot-Wax Process.* In this process, *Finnell-Kote Solid Wax* is used, and it is applied mechanically with *Finnell Equipment.*

Hot-waxing affords greater penetration—allows the wax to *flow* into the pores of the floor—and thoroughly utilizes the wax solids. *Hot-waxing with Finnell-Kote,* whose genuine wax content is three to four times greater than average wax, produces a finish unique in wearing and protective qualities. Shows substantial savings in labor costs, on a year-to-year basis, as a result of fewer applications required. *Finnell-Kote* is heated in a *Finnell-Kote Dispenser* attached to a *Finnell Machine.* The melted wax is fed to the floor through the center of the brush ring, and is uniformly and rapidly spread by the revolving brushes. *Sets in less than ten seconds,* and polishes to a beautiful, non-skid finish that actually *seals out* dirt and grime. Contains genuine Carnauba.

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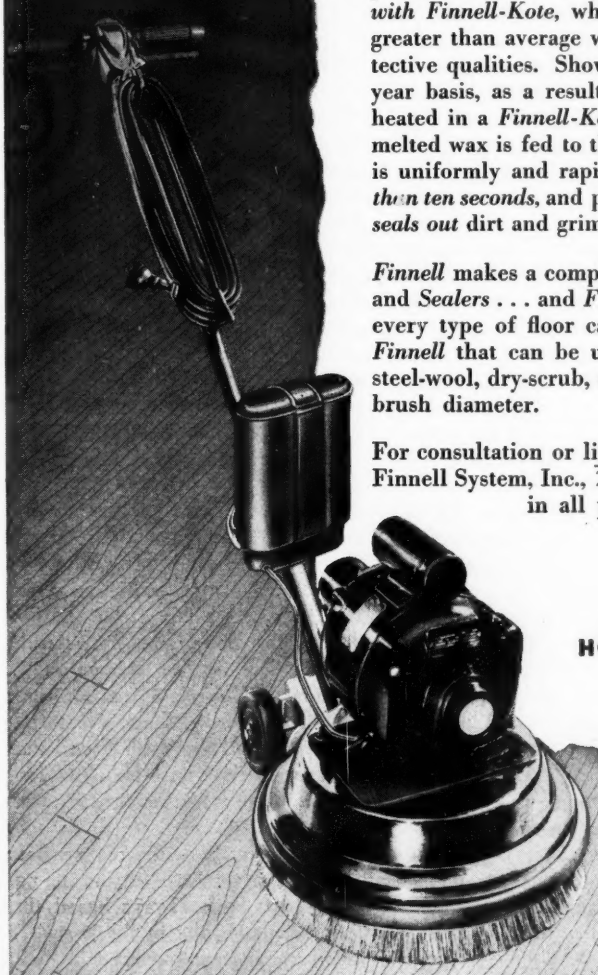

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BRANCHES IN ALL PRINCIPAL CITIES

How laundry aids patient's welfare and speedy recovery

by Mrs. Agnes W. Boyle Assistant administrator • Herrick Memorial Hospital • Berkeley, California

■ HEAVEN FORBID that the day will ever come when laundry managers are accused of practicing medicine! But it goes without saying that the practice of medicine and hospital administration would unquestionably be handicapped without the cooperation of the laundry manager and his staff of workers.

It is not my intention to depreciate or slight in any way the medical or hospital administration professions, but rather to point up the important role which laundry managers everywhere play in the welfare and speedy recovery of the patients.

For a few moments imagine yourself, the laundry manager, stealing an added career, that of the family general practitioner. You are garbed in a stiff, white, doctor's coat, making your daily rounds, writing orders on patients' charts, prescribing a hypo for pain, aureomycin t.i.d. and a 1,200-calorie daily diet for a cholesterol sufficiency patient.

An impostor . . In spite of your probable charming bedside manner, without the proper credentials it wouldn't be long before the staff doctors would investigate your activities, throw up their hands in holy horror and send for the officers of the county medical society and the sheriff to have you properly jailed and indicted for committing this crime against the medical profession. They would rightly call you an *impostor.*

Should you work your little crime in more humane institutions which offer the more elite accommodations of psychiatric departments, you would probably be escorted, sans the straight jackets, to bide your time for first class psychoanalysis and observation to determine the *whys* of your schizophrenic personality and the *wherefores* of impersonating a first class doctor of medicine.

This little role-playing sounds ridiculous on the surface and you are probably saying to yourself: "If I wanted to be a doctor, I would have studied medicine instead of being a first class laundry manager, finding myself sitting here listening to Mrs. Boyle."

Permit me to take you back on our hypothetical merry-go-round, back, that is, to the scene where you were minding your own business in the laundry before I ever came along and got you into the scrape with the law.

Serving patients . . Let's take another look and see *just where the laundry manager fits into the practice of medicine.* If we analyze this hypothetical situation of laundry managers practicing the fine art of serving patients, the comparisons between the two professions are not as far-fetched as this sounds. Incidentally, I hope that one of these fine days . . between the soapsuds, the sour bath, the pH and the starch . . laundry managers will get together with laundered pen in hand and fill the hospital literature with articles about the *laundry's contribution to the patient's welfare* so that the next time one of us ("not-so-dry-behind-the-ears" speakers) will be able to prepare an honest-to-goodness scientific paper on the importance of the laundry to the patient's recovery.

Even in various job descriptions for laundry managers mention of *the patient* is omitted or obscure. The laundry manager supervises workers engaged in cleaning, washing, and ironing clothes, linens, etc., in the laundry; he assigns jobs to workers, regulates flow of work, trains new employes, maintains production records, calculates production costs, and requisitions supplies, makes plans for additions or changes in location of equipment, etc. . . . But *the patient! Where, oh where, is the patient?*

There goes our family physician, the real one this time, calling on *the patient,* and where are you, the laundry manager? Right behind him, waiting outside the patient's room. Gosh, he has been in there a long time; must be a difficult patient to diagnose . . . finally, out he comes, a frown on his face and his shoulders bent . . . he is muttering something about this age of specialization to the nurse who is trying to decipher his written orders which he leaves for her to carry out: hypo for pain; aureomycin t.i.d., etc.

Laundry prescription . . You can't resist a visit to the patient's room. A look of astonishment and horror clouds your face. There on the cold bare springs is the sick patient garbed in his street clothes; no bedding, no curtains between the beds for privacy, no drapes on the windows, no towels: *and the nurse* is wearing a housedress, a print one at that, which she wore from home. You wonder to yourself: How long is it going to take this *patient to get well?*

Then you suddenly realize *your* tremendous responsibility to the patient (you have always heard that the patient is king in the hospital). What kind of treatment is this? So you whip out your magic instrument and start ordering things you think the patient needs: As you write and work your magic, the items appear instantly and fall into proper place:

"Patient Jones to have:

1 mattress and pillow, especially

the hospital calendar

List Your Meetings

As soon as the dates for the next succeeding meeting of an organization have ben determined an official should forward those dates at once to Editor, Hospital Management, 200 E. Illinois St., Chicago 11, Ill. to insure appearance in this calendar.

August

18-22 . . ACHA Midwest Institute, Boulder, Colo.

25-29 . . American Congress of Physical Medicine, The Roosevelt, New York, N.Y.

September

2-12 . . ACHA Institute, Chicago.

8-12 . . ACHA Advanced Institute, Chicago.

10-12 . . Biological Photographic Association, Hotel New Yorker, New York, N.Y.

13-18 . . Hospital Management public relations meeting, American College of Hospital Administrators, American Hospital Association, American Association of Nurse Anesthetists, Hospital Industries Association, Philadelphia.

22-26 . . American College of Surgeons Clinical Congress, Waldorf-Astoria, New York City.

26-27 . . Wyoming Hospital Association, Memorial Hospital, Rock Springs, Wyo.

28-Oct. 1 . . National Association of Clinic Managers, Palmer House, Chicago. President, Harold R. Heberlein, The Jackson Clinic, 16 S. Henry St., Madison, Wis.

October

6-7 . . South Dakota Hospital Association, Alex Johnson Hotel, Rapid City, S.D.

13-17 . . AHA Institute on Laundry, Sheraton Hotel, Detroit, Mich.

13-17 . . American Association of Medical Record Librarians, Shoreham Hotel, Washington, D.C. Executive secretary, Doris Gleason, R.R.L., 510 N. Dearborn St., Chicago 10, Ill.

16-17 . . Mississippi State Hospital Association, Heidelberg Hotel, Jackson, Miss.

20-24 . . AHA Institute on Nursing Service, Claremont Hotel, Berkeley, Calif.

21-24 . . American Dietetic Association, Municipal Auditorium and Hotel Radisson, Minneapolis, Minn.

22-23 . . Washington State Hospital Association, Cascadian Hotel, Wenatchee, Wash. Executive secretary, John Bigelow, 370 Skinner Building, Seattle 1, Wash.

22-24 . . Manitoba Hospital Association, Royal Alexandra Hotel, Winnipeg, Man.

23-28 . . American Physical Therapy Association, Bellevue-Stratford, Philadelphia, Pa.

27-29 . . Ontario Hospital Association, Royal York Hotel, Toronto, Ont.

29-30 . . Vermont Hospital Association, Pavilion Hotel, Montpelier, Vt.

November

6-7 . . Colorado Hospital Association, Cosmopolitan Hotel, Denver.

6-7 . . Oklahoma State Hospital Association, Skirvin Hotel, Oklahoma City. Secretary, Cleveland Rodgers, 4900 S. Lewis Ave., Tulsa, Okla.

6-7 . . Colorado Hospital Association, Denver.

6-7 . . Kansas Hospital Association, Town House, Kansas City, Kans.

10-11 . . Maryland-District of Columbia-Delaware Hospital Association, Hotel duPont, Wilmington, Del. Executive secretary, A. K. Parris, 200 W. Baltimore St., Baltimore 1, Md.

10-14 . . AHA Institute on Purchasing, Sheraton Hotel, St. Louis, Mo.

10-14 . . AHA Institute on Accounting, Knickerbocker Hotel, Chicago.

13-14 . . Nebraska Hospital Association, Pathfinder Hotel, Fremont, Neb.

20-21 . . Illinois Hospital Association, Hotel Abraham Lincoln, Springfield. Executive director, James R. Gersonde, 105 W. Adams St., Chicago 3.

20-21 . . Missouri Hospital Association, Hotel Jefferson, St. Louis, Mo. Executive secretary, Irene F. McCabe, 4904 Delmar Blvd., St. Louis 8, Mo.

December

1-5 . . AHA Institute on Housekeeping, St. Charles Hotel, New Orleans, La.

1953

January

20 . . Massachusetts Hospital Association, Sheraton Plaza Hotel, Boston. Executive secretary, Henry G. Brickman, 14 Somerset St., Boston 8, Mass.

February

10-13 . . American Protestant Hospital Association, Palmer House, Chicago, Ill. Executive director, Albert G. Hahn, Protestant Deaconess Hospital, Evansville 11, Ind.

11-12 . . National Association of Methodist Hospitals and Homes, Palmer House, Chicago. Executive secretary, Karl P. Meister, 740 Rush St., Chicago 11, Ill.

April

6-9 . . Ohio Hospital Association, Netherland Plaza Hotel, Cincinnati. Executive secretary, Room 414, 55 E. State St., Cleveland 15, O.

May

4-6 . . Tri-State Hospital Assembly, Palmer House, Chicago, Ill. Executive secretary, Albert G. Hahn, administrator, Protestant Deaconess Hospital, Evansville 11, Ind.

designed for comfort
1 clean mattress pad, rubber sheet
2 sheets, draw sheet, pillowcases (without stains or tears, please) a day, or as necessary
Blankets to suit the patient's desires
1 bed spread, preferably in color

How do YOUR housekeeping costs compare with those on page ten ?

Gay drapes at the windows, curtains between the beds for privacy
Fresh towels and washcloth for the daily bath, and yes, a sparkling clean gown for the patient, so he can get out of his street clothes and be more comfortable.

P.S. And the nurses can pick up crisp uniforms any time their little hearts desire."

"There, that's better," you say, as you survey the comfortable surroundings and receive an appreciative smile from your patient.

Just then your administrator comes along and nods approvingly, but reminds you that there are 199 *more* patients to make equally comfortable, and then you are paged!

Call for laundry manager . . The switchboard is buzzing with calls for the laundry manager . . here is one from surgery: "Please hurry with your magic and send us sterile drapes for the surgery patient, and gowns and masks for the scrub nurses and the doctor is wringing his scrubbed hands waiting for his gown, cap, mask and yes, even his gloves." The doctor is still muttering and you can hear him over the phone saying, "Couldn't some special status or degree or knighthood be conferred on our laundry manager for making my practice of medicine and surgery more possible?"

You are still glowing from the warmth of the handshake which the chief of the obstetrical service gave you after you showed him the laboratory report on the final rinse water used for the infants' clothes. That rash that appeared on the babies' spankers came not from the laundry, as he had first suspected, but resulted from too much sugar in the baby formula.

You are pretty much up in the clouds for having been called in on consultation for the severe skin case on third floor. It was brought out that the patient's very life depended upon very frequent changes of sterile linen: perhaps as many as from 3 to 6 complete sets every 24 hours. Of course, you would take care of it, *immediately* . . and with your laundry magic, you *help* to save a person's life.

Then x-ray and physical therapy call you at the same time: and two voices echo simultaneously, "Our patients would be more comfortable and the diagnostic studies and treatments would be more effective if you could arrange to have their clean linen in the departments every morning before seven." You oblige. Then before the noon meal, dietary department calls and says that the patients would probably enjoy luncheon more, and patients' gowns and bedding would be protected, if you could find it in your heart to supply some napkins for their trays.

Hardly had you put the phone back in the cradle, when the outpatient clinic gives you their story about the need for clean linen for the pediatric and maternity clinics. With a flash of your magic instrument these patients too are served with the best in the way of linen you can give them.

At lunch you learn from the telephone operator that you have had more calls in one morning than the administrator, and that's going some.

Relaxing a bit before starting your afternoon work, and feeling just like a king yourself, you think how lucky you are to have the magic of the laundry manager which made all of your morning laundry tricks for sick patients possible. Then you wonder and try to analyze what makes your magic instrument produce all of the happiness which you had been dispensing so easily all morning. You ask yourself these questions:

Is my magic created by my efficient extractor operator, or flatwork ironer, or my marker-sorter, or hand presser, or machine presser, or flatwork shaker, or tumbler operator, or washer foreman, or the washman? Is any one person more important than any other in getting the linen in the hands of the patient? Perhaps these people working as a team make my magic possible? No, the magic dispenser does not react yet.

How do YOUR plant operation costs compare with those on page ten ?

Questions still flow through your wrinkled brow. Does the housekeeper contribute to my magic, the seamstresses, the floor maids, the purchasing agent, the doctor, the administrator, the laundry manager, *the patient?*

Then suddenly your magic rod vibrates and you know the secret! The *patient is king and is treated like one only* when each and every hospital staff member works in complete harmony and coordination for the patient's pleasure and comfort and only then will the laundry manager's magic work. Only then will *your* patients feel the extent of your magic and the luxury of your ample supplies of well laundered linen, distributed in advance of the need.

I hope that there will come a day when a grateful patient will send a request accompanied by an appropriate check to the hospital to finance a suitable plaque to be placed over the entrance to the hospital laundry with this inscription:

"In Sincere Appreciation to the Laundry Manager and Workers Who Contribute so Generously to the Welfare and Speedy Recovery of Patients." ■

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GEORGE C. BRAINARD
President, Addressograph-Multigraph Corporation

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Payroll savers are serious savers. Since May, 1951, through April, 1952, E Bonds maturing totaled $2,345,000,000. But, only $593,000,000 of these matured bonds have been presented for payment. 75% of these matured bonds are still held by their purchasers.

As President of one of the first companies to install the Payroll Savings Plan when it was presented to industry in 1942, Mr. Brainard also appreciates the benefits that accrue to a company that has a Payroll Savings Plan with more than 60% employee participation. In company after company, absenteeism has gone down, the accident rate has fallen off and production has gone up as employee participation passed the 60% mark.

What is the percentage of *your* employee participation? If it is less than 60%, get in touch with the Savings Bond Division, U.S. Treasury Department, Suite 700, Washington Building, Washington, D.C. Your State Director (listed in telephone books under "Savings Bond Division" as well as "U.S. Treasury Department") will be glad to show you how easy it is to reach 60%, 70%, or higher through a simple person-to-person canvass that puts a Payroll Savings Plan Application Blank in the hands of every employee. Phone, wire or write today.

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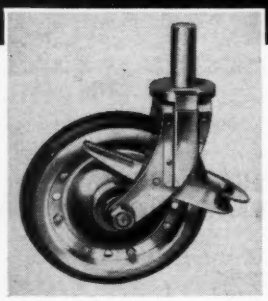

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Trends

continued from page 97

Early results were far from encouraging if viewed in the light of critical evaluation. Anti-bacterial antibodies can be induced in laboratory animals by stimulation with dead or living bacteria, but not with the ease or degree of success possible with diphtheria toxin.

Production is slow; sharply defined antigenic differences exist among bacterial strains which broadly fall within the same genus. Absence of a full understanding of these differences resulted in the production and use of anti-bacterial serums which failed to produce the therapeutic effect expected. This lack of knowledge led to abuse by the manufacturers of biologics and to the inability of the physician to correctly treat his patient.

Further research demonstrated these antigenic differences between strains or types of bacteria which formerly had been considered the same because of their similarity in morphology and cultural characteristics. However, this precise knowledge and its implications has been slow in changing manufacturing practice and the immunological thinking on the part of the family physician.

Great improvements . . It is probably natural that this period of uncertainty and exploitation should follow the original observations. Those original accomplishments were truly spectacular and occurred at a time when infectious diseases ravaged entire communities at will.

Research work in the field of bacteriology, immunology and epidemiology has largely replaced that intervening period when it often was the practice to produce biologic products without adequate laboratory control tests or their clinical use without prior evaluation by carefully controlled human trials. We can say today that we are coming to the end of another era. This one has witnessed great improvements in the quality of biologic products and a demand that each product be subjected to impartial and critical evaluation as to its prophylactic or therapeutic efficacy. Some of the accomplishments of the last one or two decades deserve mention in this discussion.

We have witnessed significant improvements in the culture media used in the commercial production of biologic products. This includes the development of artificial media based on the specific growth requirements of the organism and the recognition of the embryonated hen's egg for cultural purposes.

We have witnessed improvement in the selection of animals for the production of antiserums and in methods of stimulating antibody formation in these animals. We have witnessed the development of a series of useful diagnostic skin tests and detoxified antigens, particularly diphtheria and tetanus toxoids.

We have witnessed improvements in the purification and concentration of antitoxins, antiserums and antigens. This includes enzyme digestion in order to reduce molecular size, fractionation by means of variations in solubilities, purification by ultra-filtration and fractional centrifugation and purification by means of selective absorption.

We have witnessed to a great extent the elimination of allergenic substances from culture media used in preparing antigens or their elimination through suitable processing of both antigens and antiserums. Where this has not been possible the user is informed by suitable warning on the label.

Biologic Tests . . We have witnessed the development of satisfactory biologic tests for pyrogenic substances. Its application in manufacturing processes has resulted in the elimination of pyrogenic reactions following the use of most biologic products as well as other parenteral liquids.

We witnessed improvements in culture media used for the sterility test and have seen the establishment of more critical requirements for sterility and purity. These have been paralleled by a demand on the part of the physicians that every biologic should be harmless to the patient when administered in the manner directed on the label.

We have witnessed a general acceptance of the philosophy that no biologic product should be offered

to the public without prior evidence of efficacy. This has been accompanied by the development of additional potency tests and the improvement of others. It has also led to the adoption of a greater number of reference standards and the use of these add greater significance and uniformity to the interpretation of the complex biologics tests involved in the potency test.

We have witnessed a definite improvement in the scientific training and technical qualifications of those persons responsible for the manufacture of biologic products. They now enjoy equal scientific standing with their colleagues who have accepted positions of equal responsibility in our universities or research institutions.

We have witnessed a more critical attitude on the part of the physician toward therapeutic products of all sorts. He is more insistent that the manufacturer provide him with preparations of high and uniform potency, free from toxic impurities and labelled so as to accurately describe the therapeutic component.

Proven products . . The foregoing review should serve as a guide to the future trends in the field of biologic products. It should be clear that only products of proven prophylactic or therapeutic value are desired either by the clinician or health officer.

Because of their composition and need for administration by the parenteral route biologic products are always potentially dangerous. Their use, therefore, should be determined on the basis of the beneficial result to the patient as against the potential danger involved. The physician does not hesitate to give diphtheria antitoxin when he is confronted with a laboratory confirmed diagnosis of diphtheria. However, he does hesitate to use it prophylactically in children who have had only a casual contact with a clinical case of the disease.

Trends in the field of therapeutic biologic products have been greatly influenced by research and development in the field of antibiotics and sulfonamide chemotherapy. This will continue to be the case. Indeed one would be mentally blind not to recognize the superiority of sulfadiazine or penicillin in the treatment of meningococcus meningitis or pneumococcus pneumonia over the use of the corresponding type specific anti-serums. On the other hand the treatment of tuberculosis in any of its forms with streptomycin leaves much to be desired.

Demand for immunity . . The availability of these new efficacious and harmless therapeutic substances for the treatment of infectious diseases has not lessened the demand for biologic products which are capable of preventing disease through active immunization. A fully protected individual is a more useful member of society than one subject to frequent illness even though his illness may be cured in a few days and without sequelae.

Thus far sanitary measures have not succeeded in eradicating the infectious diseases. This leaves active immunization as the only available means of fully protecting the individual. The only preparations at our disposal to effect this type of immunity are antigens produced by the infecting micro-organism. This may be an attenuated living organism as in yellow fever vaccine, a living variant strain as vaccine virus in smallpox vaccine, a killed culture suspension as in typhoid vaccine or a cultural filtrate as in diphtheria or tetanus toxoids.

Antigens vary in their ability to stimulate durable immunity. Tetanus toxoid establishes a rather durable immunity which completely protects the individual against all degrees of infection and strains. On the other hand, influenza virus vaccine stimulates an immunity of short duration, of low titer and one which is sharply limited because of differences in the antigenic pattern of the numerous prevailing strains of the virus.

Chemical structure . . The chemical structure of antigens are understood only in general terms. However, there is sufficient knowledge to make it appear most unlikely that synthesis will be an accomplishment of the near future. This leaves the problem of producing each antigen one of cultivation

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The cover picture

■ NEW YORK HOSPITAL, shown here in all its majestic grandeur, traces its history to pre-revolutionary times.

After entering into a teaching affiliation with Cornell University Medical College in 1912 rapid progress was made. In 1932 the hospital and medical center opened the buildings shown in the picture, creating The New York Hospital-Cornell Medical Center.

in a suitable laboratory medium, its purification a problem for the immuno-chemist and the determination of its potency possible only through complex biological tests. Continued research can improve each of these procedures.

In the future, developments in the field of biologic products and in the fields of antibiotics and synthetic chemo-therapy will need to be evaluated by the same standards. These are freedom from harmful reactions in the patient and ability to quickly and completely effect a cure. On this basis most of the anti-serums have already lost first position as the therapeutic of choice in treating the corresponding disease.

Antitoxins remain the only substances capable of neutralizing exotoxins. Where these toxins are highly lethal and quick-acting, as in diphtheria, the need for antitoxin in the successful treatment of infectious diseases will continue. Active immunization against disease is possible only through the use of specific antigens derived from the etiological organism. There is no evidence at present that their use will not continue and without direct competition either from an antibiotic or a synthetic chemical.

Research is needed to improve those biologic products which continue to be needed either for therapeutic or prophylactic use. Even to a greater extent research is needed to complete our knowledge of the immunity mechanism within the living body and to clarify those immune reactions demonstrable *by vitro* reactions between antigen and antibody. ■

Go Away!

continued from page 60

Northwest, and all of the great areas between, there are unlimited opportunities for the vacationer, whether worn down by the job or only eager for new experiences.

Get away from it all, and come back revitalized. Everybody should do it, most of all in these difficult and trying times. ■

It all depends

■ IN A RELEASE discussing various angles of the work of the Federal Security Agency during 1951, Administrator Oscar E. Ewing is quoted as taking considerable pride in the fact that "At least 1,200,000 people 65 and over were in paid jobs by January, 1951, a rise of about 40 per cent over the year before." Credit is taken for this because, it is pointed out, the Federal Security Agency "is largely responsible for conservation of America's human resources."

Without going into the question of just how this has enabled an increase in the number of workers 65 and over, another point comes up to make the casual observer wonder why Mr. Ewing chose to bring this matter up at all. It relates to the now well known fact that the worker of 65 and over, eligible to receive his hard-earned OASI benefits, is ordinarily inclined to stick to his job as long as he can, because the retirement benefits are absurdly inadequate save as a meager supplement to other resources. Further, it is involved with the fact that once a beneficiary has retired, he is penalized . . that is the only possible word . . for going back to work, in the defense program or any other "covered employment," by being deprived of his benefits if he earns more than $50 a month. Moreover, he is given pause when considering going back to work, whether from a desire to be of service to his country or otherwise, by the heavy taxes which his earnings would have to bear, making it necessary, if he is to break even on his puny OASI payments, to figure his net pay, less federal and other taxes and the resumed deductions for Social Security, and try to find out what he is going to get out of his work.

All this makes it reasonable to inquire how many of this 1,200,000 group of 65 and over, in paid jobs a year ago, had ever found it possible to retire under their so-called Social Security benefits, and how many, if any, of them had come back from retirement to resume work. It is pretty safe to venture the opinion that very, very few are in the latter class, for the obvious reason suggested. It happens to be a fact that most of the elderly, over 65, have to accept reduced pay, or work on a part-time basis; and it is difficult to figure much of a net for them under such circumstances in giving up retirement benefits, however limited, for an added income so small as to be not worthwhile.

If the powers that be in Washington really desire to provide incentive to people of 65 and over to return to work once retired, the obvious course for them is to amend the Social Security statute to the simple effect of removing the present severe and indefensible limit on earnings, and the penalty of forfeiting the supposedly earned retirement benefits by receiving more than $50 a month. This would in all probability bring back to payrolls, when needed, a great many of those who have decided to try living on OASI plus earnings of less than $50 a month, and would also place the federal government in a much more commendable position in this matter. Instead of trying to push the proposal to give free hospital care to those over 65, which Congress is not likely to adopt, why not try this? ■

Forty thousand World War II veterans have lost some or all of their sense of hearing.

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—The Chemical Digest

Lure nurses with scholarships

■ NURSING SCHOOL SCHOLARSHIPS for young women of their county is one way which the Robert T. Mather Hospital of Port Jefferson, N. Y. has selected to help overcome the shortage of professional nurses. This is a small rural hospital with 76 beds and 24 bassinets. It does not have a school of nursing.

The scholarship plan has been worked out by a nursing committee appointed last fall by the president of the board of directors and headed by Robert Pelletreau of Patchogue, N. Y. Three scholarships have been provided, one by a member of the board, one by the women's auxiliary and one by hospital personnel. It is expected that one or two more may be provided by this fall.

Each scholarship will pay $500 toward the cost of a nursing education. The scholarship recipients are being selected by a committee on the basis of her letter of application, replies given on the application form, references, scholastic standing and personal interview. Each scholarship recipient is asked to agree to work for Robert T. Mather Hospital for two years following graduation at the prevailing salary scale.

Radio and press publicity about the scholarship plan and nursing as a career have brought many inquiries from prospective applicants. The interest of the hospital personnel was voluntary and a square dance netted $400 toward the scholarships to be provided by this group. Another group plans to give a semi-formal dance in August to raise funds for a scholarship. Miss Myrtle DeYoung, R. N. is superintendent of the hospital. ■

N.Y. bed inventory

■ THE GREATER NEW YORK metropolitan area now has 47,475 hospital beds, according to the annual inventory of the Hospital Council of Greater New York, this figure being 1,062 more than that of a year ago. Hospitals of all types are included. The beds for general care, 70.5 per cent of the total, number 33,463, the next largest group, tuberculosis, numbering 6,112, and those for chronic diseases 5,077. ■

Blood Preservation

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suspended red cells, following the technique of Strumia carefully, have given laboratory evidence of satisfactory preservation for at least three months.

Substitution of 0.3 per cent or 0.6 per cent solutions of Versene in isotonic saline for neutral isotonic citrate solution as an anticoagulant, but otherwise following the technique of Strumia, has yielded laboratory data suggesting improvement in the aging of whole blood as compared to blood collected in ACD solution. The improvement does not appear to approach that obtained when the methods of Strumia are followed precisely.

Extensive research . . Search for a plasma protein interacting specifically with the erythrocyte membrane has been extensive. Gibson found evidence of such a protein in Fraction IV-3, 4, but his work has never been extended. Recently, in Fraction III-1 such a protein seems to have been found in our laboratory. Identity of the protein has not yet been established but it appears to be a lipo-protein which could readily be made available during routine plasma fractionation.

One major difference between blood in the bottle and blood in the body is the repeated exchange of carbon dioxide for oxygen in the lung. Attempts to oxygenate blood during storage have suggested that this may be a very hopeful technique and may provide the key to correlation of data from studies which have hitherto been baffling. Present effort is being devoted to devising a means of ready continuous oxygenation during storage so that this phenomenon may be accurately evaluated.

In summary, although we cannot begin tomorrow to keep blood for months, techniques may have already been reported that will be shown by corroborative studies to provide for a major extension of our ability to keep both whole blood and active research in the field gives resuspended cells. Certainly, the great promise of advances in our knowledge of blood. ■

75th birthday for N.Y. School of Nursing

■ THE NEW YORK HOSPITAL School of Nursing recently celebrated its 75th anniversary, together with the tenth anniversary of its status as a school of Cornell University, whose medical school is connected with the hospital. One of the leading collegiate schools of nursing in the country, it was pointed out by Miss Annie W. Goodrich, who was graduated from the school in 1892, that at that time not even a high school education was required for entrance, as compared with the present requirement of two years of college. Miss Goodrich, who now lives in Colchester, Conn., became head nurse in The New York Hospital following her graduation from the nurse-training school, and later became superintendent of nurses there, also holding a similar position with other leading hospitals, before becoming dean of the Army School of Nursing during the war, dean of Yale University School of Nursing, and holding faculty positions in other institutions.

The enrollment of students in the school 75 years ago was only 7, as contrasted with the present figure of 200, and the alumnae total 2,076. The nursing school and its students are housed in one of the handsome 16-story buildings which comprise the spectacularly beautiful group of structures devoted to the various purposes of The New York Hospital.

Miss Katharine Lenroot, former chief of the United States Children's Bureau, was principal speaker at a dinner in honor of the occasion at the Plaza Hotel, and Miss Minnie H. Jordon, of the class of 1902, who was director of nursing at the hospital from 1916 to 1932, became the second nurse in the hospital's history to receive the award of a "president's chair" from the board of governors of the Society of The New York Hospital. Miss Jordon is now director of volunteers at the French Hospital. ■

Between 15,000,000 and 20,000,000 persons in the U. S. have defective hearing to some extent in one or both ears; 5,000,000 to 8,000,000 have serious hearing defects.

Free Medicine

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wary about curtailing the system, even in the face of mounting costs. There is an urge in the lower and middle income groups to "get something" out of the system. Most people are more impressed by the fact they get no doctor bills than they are by the delays and red tape that often go with public-health treatment.

The absence of bills does not mean, of course, that socialized medicine is free. The system is financed by the taxpayers themselves, whether they use it or not. Eighty-six per cent of the cost is met by general tax revenue. Payroll taxes deducted for social security pay an additional 10 per cent and the balance comes from local property taxes.

The basic issue . . that the Churchill Government is up against now is the question of just how much the country can afford to spend for health.

The Labor Party, which established the health program in the first place, has been showing more and more strength in public-opinion polls and in local elections lately. Its leaders have announced officially that if the party is returned to power it will cut out the few direct charges patients now pay and return to 100 per cent socialization.

The Socialists intend to restore a system that is wholly tax-paid on the ground of social justice . . that full treatment should be equally available to everybody . . even though some authorities insist the expense of public health already is outrunning the nation's capacity to pay.

On the other hand, Churchill's Conservatives, in charge of the program now, are not inclined to do anything drastic about curtailing it . . either in cost or in the scope of the services available. Just touching the system causes political explosions the party cannot afford.

Socialized medicine in Britain has turned out to be so potent politically that it is going to be continued, whatever the cost. ■

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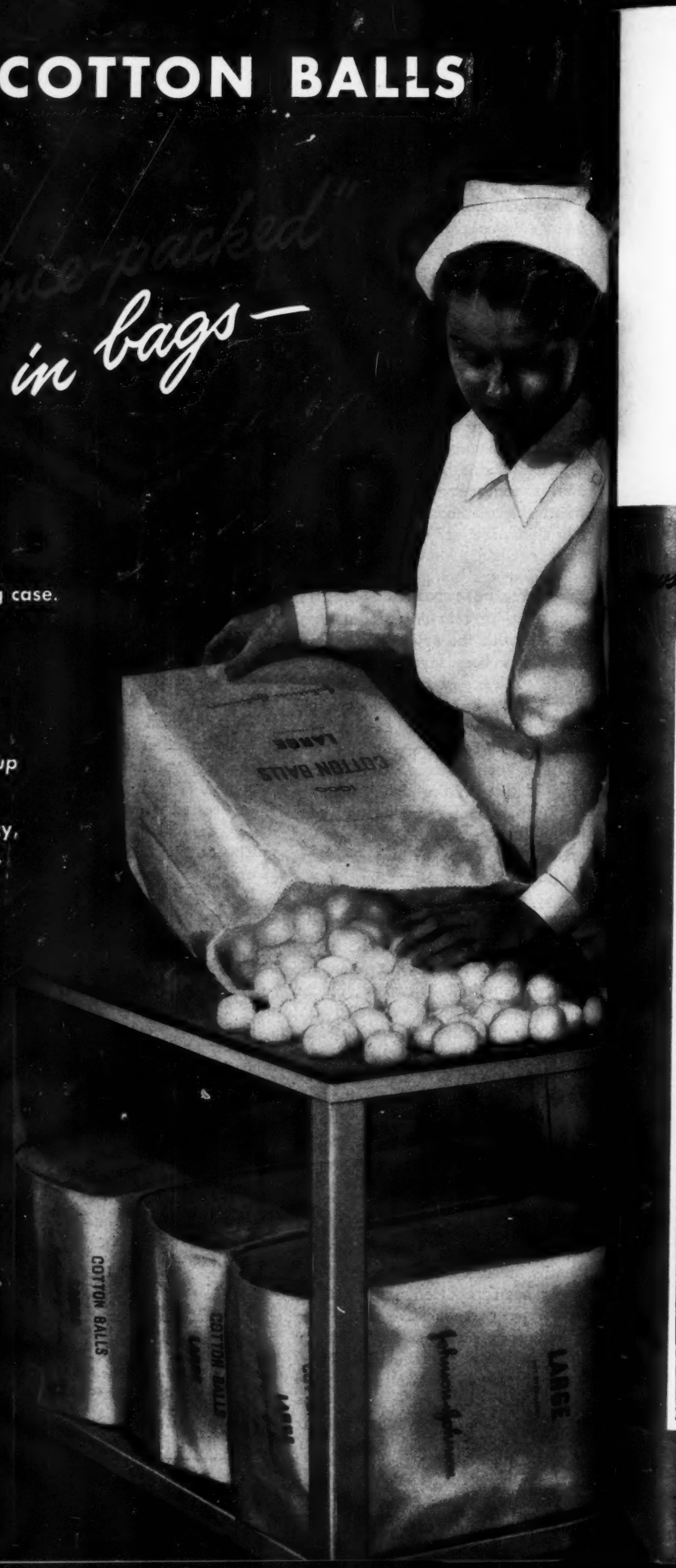
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